Wyoming Medicaid Annual Report
State Fiscal Year 2011

Wyoming Department of Health

Division of Healthcare Financing

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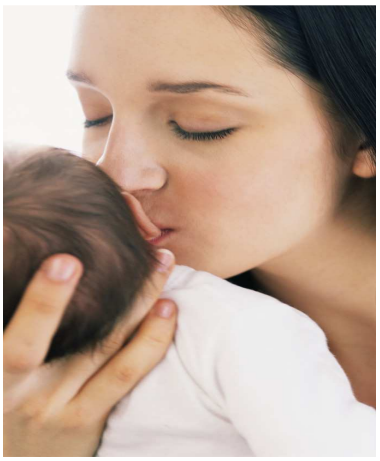

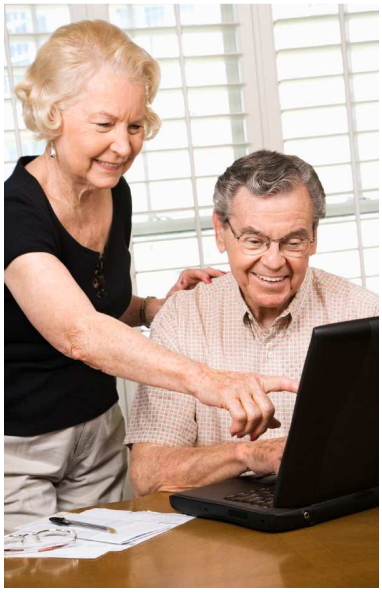

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SECTION 1: INTRODUCTION

Annual Report Overview

- The Annual Report is designed to assist in providing timely information by eligibility category and service area and in the aggregate for the past State Fiscal Years (SFYs). The report includes a Medicaid overview and sections on Eligibility, Economy and Demographics, Services and Expenditures, Reimbursement Options, Program Integrity, and Initiatives and Subprograms.
- This Report also includes a number of appendices, as follows:
    - Appendix A provides detail about the data sources and calculations used in this Report.
    - Appendix B describes the history of reimbursement methodology changes for each service area described in this Report.
    - Appendix C provides supplementary tables and charts that support the information provided throughout this Report.
    - Appendix D provides a glossary of commonly used terms in this Report.
    - Appendix E provides a list of acronyms to reference while reading this Report.
- Prior SFY data represented in this Report do not match the data in prior SFY Annual Reports because the data criteria has changed and are re-extracted for this Report to be consistent for comparison purposes.
- For the purposes of this Report, count of eligible individuals refers to those individuals who were enrolled in Medicaid and eligible to access services. An eligible individual might or might not receive services. In contrast, "recipient" refers to individuals who received Medicaid services.
- The two ways to count individuals are to use either count or distinct count. A count, counts the number of individuals. A distinct count, counts of the number of unique individuals. A count distinct provides an unduplicated count. For the purposes of this Report, distinct count has been used to count individuals.
- Individuals eligible for Medicaid may gain and lose eligibility several times in one SFY. Individuals who are eligible at one point in time may not be eligible at other times of the year. Other individuals may retain eligibility throughout the year. As such, the distinct count of individuals eligible for Medicaid for a complete SFY (regardless of how long they were eligible) will be greater than a point-in-time count of individuals eligible for Medicaid.

Wyoming Medicaid Overview

- Medicaid provides medical assistance for low-income and medically vulnerable citizens. There are four major categories of eligibility: children; pregnant women; family care adults; and the aged, blind or disabled. The eligibility categories are discussed in detail in Section 2 of this Report.
- Medicaid covers mandatory services as required by the federal government and optional services authorized by the Wyoming Legislature.

Table 1: Summary of Individuals Eligible for Medicaid[1]

SFY	Eligible Individuals As of June 30	Eligible Individuals SFY
2010	69,020	87,409
2011	69,559	89,831
Percent Change SFYs 2010-2011	0.8	2.8

Administrative Cost[2]

- In SFY 2011, the cost of administering Medicaid was approximately $28 million, with an administrative cost percentage of approximately 5.25 percent of total Medicaid expenditures. Of the $28 million in administrative costs, 23 percent was for salaries; 6 percent was for supportive services such as rent, mailings, travel, and supplies; and 71 percent was for contract services, including the Medicaid Management Information System (MMIS) contract, the Pharmacy Benefit Management (PBM) contract, the Healthy Together Health Management contract, and the Health Utilization contract.

[1] 'Eligible Individuals As of June 30' is a distinct count of individuals at a point in time. 'Eligible Individuals SFY' is a distinct count of individuals for a complete SFY.
[2] Administrative costs provided by fiscal staff and are based on total Medicaid expenditures excluding CHIP.

SECTION 2: ELIGIBILITY

Eligibility Overview

- Medicaid eligibility is based on residency, citizenship and identity, social security eligibility as verified by social security number, family income and, to a lesser extent, resources or health care needs.
- Since 1996, Medicaid eligibility has been separate from eligibility for economic assistance to families with dependent children. Twenty years ago, most individuals receiving Medicaid services received cash assistance. The reverse is true today. Today, the vast majority of all individuals enrolled in Medicaid are not receiving any cash assistance.
- Federal statutes define more than fifty groups of individuals who may qualify for Medicaid coverage. Eligibility for some categories is determined using Federal Poverty Level (FPL) guidelines.[3] Eligibility for other categories is determined by Supplemental Security Income (SSI) standards or the Family Care income standard.[4] In many instances, differences like these are due to differences in the federal laws that created each eligibility category. Some of these standards are based on an index that changes every year (i.e., FPL or SSI standard), whereas others are not (i.e., Family Care income standard).
- Childless adults who do not fit into one of the eligibility categories described below are not currently covered regardless of income or resources.
- The Affordable Care Act enacted in March 2010 will significantly impact Medicaid eligibility policy beginning in calendar year 2014. Beginning in January 2014, states will be required to cover all individuals with income up to 133% of the Federal Poverty Level with a 5% disregard. As a result, some children currently covered by the Kid Care CHIP program will become eligible for Medicaid, parents and other caretakers of dependent children will be covered at higher income levels and there will be a new coverage group in Wyoming for other adults who have not been previously covered.

Categories

Children

- The following groups of children are eligible for Medicaid:
    - A newborn is automatically eligible if his or her mother was eligible for Medicaid at the time of the birth.
    - Low-income children are eligible if family income is less than or equal to 100 percent of the FPL or 133 percent of the FPL, depending on age of the child.
    - Family Care children are eligible when a caretaker is determined eligible (i.e., family income is less than or equal to the 1996 Family Care Standard).
    - Foster care children in Department of Family Services (DFS) custody are eligible, including some children who enter subsidized adoption or who age out of foster care when they become 18 years old.[5] The Department of Health covers medical services for children in foster care who are

[3] The 2011 FPL income standard (i.e., 100 percent) is $903 per month for a family of one, $1,615 for a family of two, $2,029 for a family of three and $2,444 for a family of four.
[4] For calendar year 2011, the SSI standard was $674 per month for an individual and $1,011 per month for a couple. The Family Care Standard established in 1996 is $362 per month for a family of one, $512 for a family of two, $590 for a family of three and $659 for a family of four.
[5] These children normally age out of foster care at age 18 and remain Medicaid eligible up to age 21.

not eligible for Medicaid using 100% state general funds. Expenditures for these children are tracked separately.

Pregnant Women

- The following groups of pregnant women are eligible for Medicaid:
  - Pregnant women are eligible if family income is less than or equal to 133 percent FPL. Women with income below the 1996 Family Care Standard must cooperate in establishing paternity for the baby so Medicaid can pursue medical support
  - Presumptive eligibility allows for coverage of outpatient services for up to 60 days pending Medicaid eligibility determination[6]

Family Care Adults

- Family Care adults (caretaker relatives with a dependent child) are eligible if the family income is less than or equal to the 1996 Family Care Standard.

Aged, Blind or Disabled (ABD)

- The following groups of ABD individuals are eligible for Medicaid:
  - SSI and SSI-related
    - SSI – A person receiving SSI automatically qualifies for Medicaid
    - SSI-related – A person no longer receiving SSI payment may be eligible using SSI criteria
  - Institution – Residents who are living in the following types of institutions are eligible if their personal income is less than or equal to 300 percent of the SSI standard. Resources are also taken into consideration. Individuals do not have to be eligible for SSI.
    - Nursing Home
    - Hospital
    - Hospice
    - ICF-MR (State Training School/Wyoming Life Resource Center)
    - WY State Hospital – Age 65 and older
  - Home and Community Based Waiver – Individuals with income less than or equal to 300 percent of the SSI standard who are in need of specific waiver services are eligible to enroll in one of the State's six Home and Community Based waiver programs. Resources are also taken into consideration. Individuals do not have to be eligible for SSI.

Medicare Savings Programs

- The following groups of individuals who are not eligible in another category and are eligible for Medicare qualify to receive premium assistance and depending on income, may qualify to receive cost-sharing assistance from Medicaid:
  - Qualified Medicare Beneficiaries (QMB) are eligible when their income is less than or equal to 100 percent of the FPL. Resources are also taken into consideration. Medicaid pays for Medicare premiums, deductibles and cost sharing.
  - Specified Low Income Medicare Beneficiaries are eligible when their income is less than or equal to 135 percent of the FPL; Medicaid pays for Medicare premiums only.

[6] Presumptive eligibility for pregnant women allows immediate, temporary Medicaid coverage for ambulatory prenatal care and prescription drugs for low-income, pregnant patients, pending their formal Medicaid application.

Special Groups

- The following special groups are eligible for Medicaid:
    - Breast and Cervical Cancer Treatment Program – Uninsured women diagnosed with breast or cervical cancer are eligible for Medicaid if their income is less than or equal to 250 percent of the FPL.
    - Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis may be eligible based on special income standards specific to the TB program.
    - Pregnant by Choice Waiver – Family planning services for women who receive Medicaid benefits through the Pregnant Woman program.

Employed Individuals with Disabilities

- Employed individuals with disabilities are eligible for Medicaid if their unearned income is less than or equal to 300 percent of the SSI standard. Employed individuals with disabilities must pay a premium. Individuals do not have to be eligible for SSI.

Non-Citizens with Medical Emergencies

- A non-citizen who meets all eligibility factors of a Medicaid group except for citizenship and social security number is eligible for emergency services.

Eligible by Category

- There were 89,831 individuals eligible for Medicaid in SFY 2011, a three percent increase from SFY 2010. Almost two-thirds of the individuals eligible for Medicaid (62 percent) were children[7].
- Individuals eligible for Medicaid reside in every county in Wyoming, and more than half reside in 4 counties: Laramie (17 percent) Natrona (15 percent), Fremont (12 percent) and Sweetwater (7 percent).

[7] The program category proportions used the sum of all eligible individuals, 93,042 total eligible individuals, to determine the percentage that each category made up of the total. This number does not match the total displayed in Table 1 as explained in Table 1 footnote.

SECTION 2: ELIGIBILITY

Figure 1: Eligible Individuals by Program Category – SFY 2011

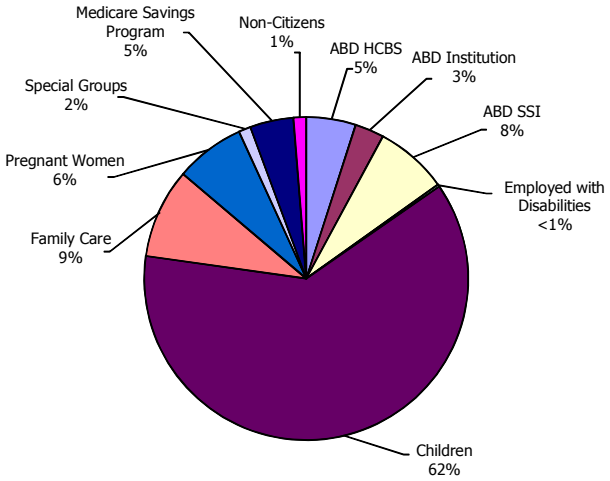


Table 1: Percentage Change in Eligible Individuals by Eligibility Category – SFYs 2010 – 2011, Arrayed by SFY 2011 Eligible Individuals

Eligibility Category	SFY 2010 Eligible Individuals	SFY 2011 Eligible Individuals	Percentage Change from SFY 2010
Children	56,117	57,609	3
ABD Total	14,030	14,014	<1
ABD SSI	*6,866*	*6,981*	*2*
ABD HCBS	*4,519*	*4,451*	*-2*
ABD Institution	*2,645*	*2,582*	*-2*
Family Care	8,047	8,302	3
Other Total	6,373	7,153	12
Medicare Savings Program	*3,954*	*4,365*	*10*
Special Groups	*1,055*	*1,447*	*37*
Non-Citizens with Medical Emergencies	*1,149*	*1,092*	*-5*
Employed Individuals with Disabilities	*215*	*249*	*16*
Pregnant Women	6,203	5,964	-4
Total Eligible Individuals[8]	**87,409**	**89,831**	**3**

[8] The number of eligible individuals in each eligibility category is the distinct count of individuals for the SFY. The sum by category will differ from the total eligible individuals in SFY 2011 because individuals may be counted in more than one eligibility category in Table 1.

SECTION 2: ELIGIBILITY

Table 2: Percentage Change in Recipients by Eligibility Category – SFYs 2010 – 2011, Arrayed by SFY 2011 Recipients

Eligibility Category	SFY 2010 Recipients	SFY 2011 Recipients	Percentage Change from SFY 2010
Children	48,303	50,035	4
ABD Total	13,504	13,650	1
ABD SSI	*5,935*	*6,096*	*3*
ABD HCBS	*4,644*	*4,712*	*1*
ABD Institution	*2,925*	*2,842*	*-3*
Family Care	6,622	6,941	5
Pregnant Women	6,388	6,158	-4
Other Total	3,426	3,694	8
Medicare Savings Program	*2,154*	*2,334*	*8*
Special Groups	*570*	*686*	*20*
Non-Citizens with Medical Emergencies	*479*	*421*	*-12*
Employed Individuals with Disabilities	*223*	*253*	*13*

Table 3: SFY 2011 Medicaid Eligible Individuals by County

Category	Number of Eligible Individuals SFY 2011	Percentage of Total Eligible Individuals
Laramie	15,214	17
Natrona	13,196	15
Fremont	10,800	12
Sweetwater	6,078	7
Campbell	5,163	6
Park	4,596	5
Albany	4,495	5
Sheridan	4,086	5
Uinta	3,964	4
Lincoln	3,037	3
Carbon	2,699	3
Goshen	2,569	3
Converse	2,107	2
Big Horn	1,674	2
Washakie	1,515	2
Weston	1,456	2
Platte	1,432	2
Teton	1,278	1
Crook	1,168	1
Johnson	1,052	1
Hot Springs	896	1
Sublette	851	1
Niobrara	490	1
Other	15	<1
Total	89,831	100

Receiving Services by Eligibility Category

- Children represented 62 percent of all individuals eligible for Medicaid in SFY 2011, but expenditures for children receiving services were only 27 percent of total Medicaid expenditures. On the other hand, the ABD HCBS population accounts for 5 percent of individuals eligible for Medicaid and 30 percent of Medicaid expenditures.
- Expenditures per Medicaid recipient also varied by eligibility category and subcategory. SFY 2011 expenditures for ABD as a group were highest at $22,304 per recipient and increased 2 percent from SFY 2010 to SFY 2011. Expenditures per recipient for ABD Institution were $34,304, a 1 percent increase from SFY 2010 to SFY 2011. Expenditures per recipient for children were $2,764 and decreased 8 percent from SFY 2010 to SFY 2011. For pregnant women, expenditures per recipient were $5,860 and increased 3 percent.

Figure 2: Percentage of SFY 2011 Medicaid Expenditures by Eligibility Category

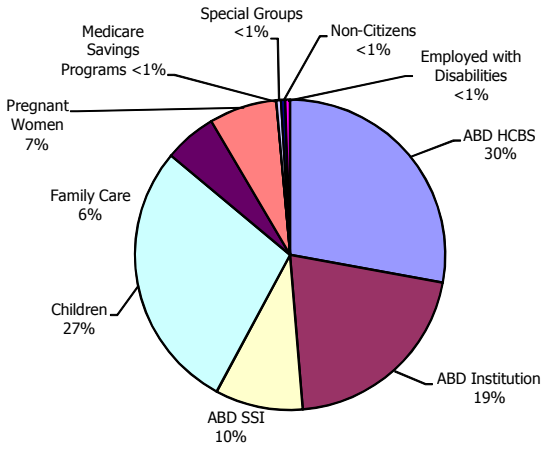


Table 4: Percentage Change in Total Expenditures for Eligibility Categories – SFYs 2010-2011, Arrayed by SFY 2011 Expenditures

Eligibility Category	SFY 2010 Expenditures	SFY 2011 Expenditures	Percent Change from SFY 2010
ABD Total	$ 295,427,634	$ 304,444,105	3
ABD HCBS	*146,381,081*	*155,016,904*	*6*
ABD Institution	*98,980,787*	*97,492,993*	*-2*
ABD SSI	*50,065,766*	*51,934,208*	*4*
Children	144,479,541	138,277,799	-4
Other Total	10,018,127	11,377,682	14
Special Groups	*2,444,944*	*3,688,749*	*51*
Medicare Savings Program	*2,562,625*	*3,007,075*	*17*
Employed Individuals with Disabilities	*2,807,582*	*2,721,026*	*-3*
Non-Citizens with Medical Emergencies	*2,202,976*	*1,960,832*	*-11*
Pregnant Women	36,184,628	36,086,835	-1
Family Care	28,237,358	29,178,291	3
Non-Eligibility Categories	182,034	239,567	32
Total	**514,529,323**	**519,604,279**	**6**

Table 5: Percentage Change in Expenditures per Recipient by Eligibility Categories – SFYs 2009-2010, Arrayed by SFY 2011 Expenditures per Recipient

Eligibility Category	SFY 2010 Expenditures Per Recipient	SFY 2011 Expenditures Per Recipient	Percent Change from SFY 2010
ABD – Total	$ 21,877	$ 22,304	2
ABD Institution	*33,840*	*34,304*	*1*
ABD HCBS	*31,520*	*32,898*	*4*
ABD SSI	*8,436*	*8,519*	*1*
Other Total	2,924	3,080	5
Employed Individuals with Disabilities	*12,590*	*10,755*	*15*
Special Groups	*4,289*	*5,377*	*25*
Non-Citizens with Medical Emergencies	*4,599*	*4,658*	*1*
Medicare Savings Program	*1,190*	*1,288*	*8*
Pregnant Women	5,664	5,860	3
Family Care	4,264	4,204	-1
Children	2,991	2,764	-8

Medicaid and Medicare Dual Eligibles

- Individuals eligible for Medicare and Medicaid are entitled to Medicare Part A (hospital coverage) and/or Part B (supplementary coverage) and are eligible for some form of Medicaid benefit.
- People age 65 or older and certain disabled persons who have insured status under Social Security are automatically eligible for Medicare Part A. People with Medicare coverage who have limited incomes may also be eligible for Medicaid services. There are various levels of Medicaid assistance available to dually eligible individuals, depending on income.
- For people who meet Medicaid eligibility requirements for full Medicaid coverage, Medicaid supplements Medicare coverage by providing services and supplies that are available under Medicaid (e.g., nursing facility care beyond the 100-day Medicare limit and dental services). Medicare pays first for services that are covered by both programs and Medicaid provides payment for any remaining Medicaid-covered services, up to Wyoming's payment limit.

- For certain other Medicare beneficiaries who do not qualify for full Medicaid coverage, limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses. For example:
    - Qualified Medicare Beneficiaries (QMBs), whose resources do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index and income less than or equal to 100 percent of the FPL, receive assistance with Medicare premiums, deductibles and coinsurance.
    - Specified Low-Income Medicare Beneficiaries (SLMB-1), whose resources do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index and income exceeding the QMB level, income more than the 100 percent of the FPL, but less than 120 percent of the FPL, receive assistance with Medicare Part B premiums.
    - SLMB-2 individuals, who are not otherwise eligible for full Medicaid benefits, with resources that do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index, receive assistance with Medicare Part B premiums if their income exceeds 120 percent of the FPL, but is less than or equal to 135 percent of the FPL. Premiums for this group are paid with 100% federal funding.
- The number of dual eligible individuals increased from SFY 2010 to SFY 2011 – 11,266 dual eligible individuals in SFY 2010 as compared to 11,638 in SFY 2011.[9] Dually eligible individuals receiving Medicaid services in SFY 2011 made up 15 percent of all individuals who received Medicaid services. Therefore, the majority of individuals eligible for Medicaid, 85 percent, were individuals who were enrolled only in Medicaid.

Children in Foster Care

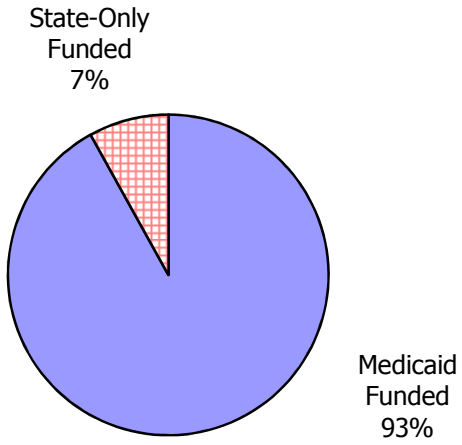
- The foster care program is administered through the Wyoming Department of Family Services (DFS). Foster care provides for the child until a more permanent plan for the child's well-being can be implemented.
- Medical coverage under foster care is intended to provide for the medical needs of foster children while in the custody of DFS. There are two types of medical coverage for foster care children:
    - Medicaid-funded, which provides medical care to foster care children who are eligible for Medicaid. According to Section 1902(a)(10)(A)(i)(I) of the *Social Security Act*, foster children covered under Title IV-E of the *Social Security Act* and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid. Wyoming also uses other existing Medicaid coverage groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state-funded subsidies.
    - State-only funded, which provides medical care to foster care children who are not eligible for Medicaid. Children in this eligibility category include those awaiting eligibility determination, those who are not income eligible for Medicaid and those in correctional institutions.

[9] For the purposes of this Report, dual eligible individuals are identified as individuals who are eligible for Medicare and Medicaid and who receive Medicaid services. As such, the number of dual eligible individuals equals the number of dual eligible recipients. See Appendix A for a description of how dual eligible individuals were identified.

SECTION 2: ELIGIBILITY

- The majority of children eligible for foster care are entitled to receive services that are paid for by Medicaid. There were 3,627 Medicaid-funded children eligible for foster care and only 293 State-only funded children eligible for foster care in SFY 2011.

Figure 3: Foster Care Children in SFY 2011



Medicaid Foster Care Children

- The number of children eligible for Medicaid funded foster care decreased by 1 percent from 3,653 in SFY 2010 to 3,627 in SFY 2011. The number of Medicaid funded foster care recipients increased by 3 percent from 3,266 in SFY 2010 to 3,349 in SFY 2011.

State-Only Funded Foster Care Children

- The number of children eligible for State-only funded foster care decreased by 10 percent from 326 in SFY 2010 to 293 in SFY 2011. The number of State-only funded foster care recipients decreased by 4 percent from 343 in SFY 2010 to 328 in SFY 2011.

Wyoming Economy and Demographics

- To strategically plan for future direction of the program, the Department must consider Wyoming Medicaid's service delivery system, reimbursement methodologies, expenditures and number of enrollees in the context of broader economic and demographic trends. The Wyoming Medicaid program is subject to external influences. Federal Legislation, the economy, demographics and other factors nationally and in the state affect growth of Medicaid expenditures and eligibility.
- In recent years, the Wyoming and national economies have experienced recession and the beginning of recovery. The national economy's recent recovery has been slow; however, Wyoming's economic recovery has been quicker than the national average due in part to the rebound of the energy industries and higher prices for both natural gas and coal.[10]
- The economy affects the number of Medicaid enrollees, as more individuals become Medicaid eligible as the economy slows. Economic forces not only affect the demand for Medicaid services, but they also have an impact on providers. Decreasing unemployment, for example, may increase the growth of health care labor costs (wages and benefits) as competition with other industries for employees increases.
- Furthermore, demographics influence health care costs. Average medical spending for adults generally increases with age, so an older population will result in higher spending.[11] However, if the recovering economy brings younger, healthier workers into the state, then health care spending for those populations may be less.

Impact of Federal Legislation

- On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA). The ACA includes provisions to expand Medicaid and private health insurance coverage and reduce the number of uninsured; the Legislation will have a major effect on Wyoming Medicaid financing, eligibility and numbers of enrollees.
- The Medicaid expansion will take place in 2014, when Medicaid eligibility will expand to all individuals under age 65 with incomes up to 133 percent of the Federal Poverty Level (FPL) with a 5% disregard, which includes non-disabled adults without dependent children. A study performed to estimate the impact of the ACA on Wyoming Medicaid projected increased Medicaid enrollment of 30,552 newly eligible individuals and 1,900 individuals who will enroll who are currently eligible and not enrolled.[12] Eventually, Wyoming will be responsible for financing part of the Medicaid costs for the expanded groups. While states will receive 100 percent Federal funding from 2014 through 2016, Federal support will gradually decrease. States will receive 95 percent Federal funding in 2017, 94 percent Federal funding in 2018, 93 percent Federal funding in 2019 and 90 percent Federal funding for 2020 and subsequent years.[13]
- One provision of the ACA provides for the creation of state-based Health Insurance Exchanges through which individuals can check eligibility and enroll in Medicaid or purchase private coverage. Currently,

[10] Wyoming Economic Analysis Division, *Economic Summary: 1Q11* (July 2011). Available online: http://eadiv.state.wy.us/wef/Economic_Summary1Q11.pdf
[11] Congressional Budget Office, *The Long-Term Outlook for Medicare, Medicaid and Total Health Care Spending.* Available online: http://www.cbo.gov/ftpdocs/102xx/doc10297/Chapter2.5.1.shtml#1092639
[12] The Lewin Group, *Impact of the Health Reform Law on Wyoming's Medicaid and Kid Care Programs*, (December 9, 2010).
[13] Kaiser Family Foundation, *Summary of New Health Reform Law* (March 2010). Available online: http://www.kff.org/healthreform/upload/8061.pdf

states are considering the advantages and disadvantages of establishing Health Insurance Exchanges or allowing the federal government to establish them. A Wyoming Steering Committee has met regularly since December, 2010 to review exchange policy options, and submitted a preliminary report to the Joint Labor, Health and Social Services Interim Committee in late 2011. As Wyoming continues to plan for implementation of the ACA, the State will need to coordinate a number of activities across Medicaid and the Exchange.

Medicaid and the Economy

- In times of economic recession, Medicaid enrollment tends to increase, as the declining economy causes individuals to lose employment and private health insurance coverage.[14] Between June 2009 and June 2010, after several years of slow or negative growth, Medicaid enrollment increased nationwide by 7.2 percent, or 3.37 million individuals, and exceeded 50 million enrollees for the first time in the program's history. Medicaid enrollment has grown by 7.6 million (17.8 percent) since the start of the recession in December 2007 to June 2010.[15] In calendar year 2011, average monthly Medicaid enrollment is projected to exceed 55 million. About 70 million people, roughly one in five Americans, will be covered by the program for one or more months during the year.[16]
- Similar to national trends, Wyoming Medicaid has experienced increased enrollment through the years of the recession. The number of Medicaid eligibles increased in Wyoming in SFY 2009 and SFY 2010 after decreasing in SFY 2007 and holding steady in SFY 2008. This pattern is consistent with national trends. However, the enrollment growth rate may be slowing. In SFY 2011, the number of Wyoming Medicaid eligibles increased slightly from SFY 2010 compared to the national increase, which may be indicative of Wyoming's quicker economic recovery compared to the rest of the U.S. Table 1 below displays these trends.[17]

Table 1: U.S. and Wyoming Annual Growth Rate in Medicaid Enrollees by SFY

SFY	U.S.	Wyoming
2007	-.6%	-3.1%
2008	3%	0.0%
2009	7.8%	9.6%
2010	7.2%	6.7%
2011	5.5%	0.8%

[14] According to a study from the Kaiser Commission, an estimated 6.9 million fewer Americans receive health coverage through the workplace due to job losses from 2008 to 2009 and correspondingly, Medicaid enrollment and the nation's uninsured increased 2.8 and 3.0 million respectively. Kaiser Commission on Medicaid and the Uninsured, *Rising Unemployment Medicaid and the Uninsured* (January 2009).
[15] Kaiser Family Foundation, *Medicaid Enrollment: June 2010 Data Snapshot* (February 2011). Available online: http://www.kff.org/medicaid/upload/8050-03.pdf
[16] Kaiser Commission on Medicaid and the Uninsured, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (September 2011). Available online: http://www.kff.org/medicaid/upload/8220.pdf
[17] Kaiser Health News, *State Medicaid Spending Skyrockets*. (October 2011). Available online: http://jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=f90af530-382f-4998-944e-d362dc9de225

SECTION 3: WYOMING ECONOMY AND DEMOGRAPHICS

Wyoming Employment Conditions

- Wyoming has historically maintained an unemployment rate below the national average, even during the recent recession, as displayed in Table 2. The unemployment rate in Wyoming was 5.8 percent in August 2011, up 2.5 percentage points from the recent low in August 2008, but down from its recent high of 7.3 percent in August 2009.[18]

Table 2: U.S. and Wyoming Unemployment Rates

Year	U.S.	Wyoming
2008	6.1%	3.3%
2009	9.7%	7.3%
2010	9.6%	6.8%
2011	9.1%	5.8%

- There were 17,000 unemployed Wyoming residents during August 2011.[19] For the first quarter of 2011, compared to the first quarter of 2010, employment grew by 3,300 jobs, or 1.2 percent. Wyoming's major industry, mining, demonstrated the fastest recovery, with an addition of 2,030 jobs, or 8.5 percent, between the first quarter of 2010 and the first quarter of 2011. Transportation and utilities, professional and business services, and construction grew more than 2 percent. The government sector added jobs at a 0.6 percent annual rate. The educational and health services industry also continued to add employees. Retail trade is the weakest sector, and continued to cut payrolls in the first quarter of 2011.[20]
- The mining industry continues to dominate Wyoming's economy. In 2010, the mining industry comprised approximately 8.9 percent of Wyoming's total employment and 31.4 percent of the state's Gross Domestic Product.[21,22]
- Overall, Wyoming's job growth from 2003 to 2010 is estimated at 12.1 percent, as displayed in Table 3, which is considerably higher than the national average rate of -.37 percent.[23]

[18] Joint Economic Committee, United States Congress, *Economic Overview and Outlook: Wyoming* (September 2011). Available online: http://jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=f90af530-382f-4998-944e-d362dc9de225
[19] Joint Economic Committee, United States Congress, *Economic Overview and Outlook: Wyoming* (September 2011). Available online: http://jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=f90af530-382f-4998-944e-d362dc9de225
[20] Wyoming Economic Analysis Division, *Economic Summary: 1Q11* (July 2011). Available online: http://eadiv.state.wy.us/wef/Economic_Summary1Q11.pdf
[21] Wyoming Labor Market Information, *Wyoming Nonagricultural Wage and Salary Employment. Preliminary Benchmark 2010.* Available online: http://doe.state.wy.us/lmi/ces/naanav9002.htm
[22] U.S. Department of Commerce, Bureau of Economic Analysis, *Gross Domestic Product by State.* Available online: http://www.bea.gov/regional/gsp/
[23] Bureau of Labor Statistics, *May 2010 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm

SECTION 3: WYOMING ECONOMY AND DEMOGRAPHICS

Population Trends

- Wyoming's population growth from 2000 to 2010 exceeded the national average (14.1 percent compared to 9.7 percent).[24] Wyoming's growth over the past decade ranked the 12th fastest in the nation. Even though Wyoming has experienced significant growth since 2000, it is still the least populated state in the U.S.[25]
- The Wyoming median age has increased from 36.2 in 2000 to 36.8 in 2010, at a rate that is slower than national figures.[26] According to the Economic Analysis Division of the Wyoming Department of Administration and Information, Wyoming has the lowest median age in the nation because labor-intensive job opportunities attract young workers to Wyoming. However, baby boomers, those born in the 1950s and 1960s, make up a large percentage of Wyoming's population. Those baby boomers will soon retire, and there are much fewer middle-aged workers to take their places.[27] The proportion of the State's elderly population (65 and over) was 12.3 percent in 2009, which is lower than the U.S. level of 12.9 percent (2009).[28]
- Wyoming had a higher percentage of high school graduates in 2009 (91.1 percent), compared to the national average of 84.6 percent. However, Wyoming has a lower percentage of individuals with a Bachelor's degree or higher (23.2 percent) compared to the national average of 27.5 percent. Median household income in Wyoming for 2009 was higher at $54,400, compared to the national average of $50,221.[29]

Wyoming Health Care Industry

- The Wyoming health care industry has experienced strong growth over the past decade and continues to grow. According to the Wyoming State Auditor, the Education and Health Services sector grew 2.0 percent from 2008 to 2009.[30]
- According to the Bureau of Labor Statistics, as of May 2010, the mean hourly wage for a Wyoming worker was $19.96, or $41,510 per year. The mean Health Care Practitioner and Technical Occupation Wage was $32.78 per hour, or $68,170 per year and Health Care Support jobs averaged $13.36 per hour, or $27,780 per year.[31] The average Health Care Practitioner and Technical Occupation wage fell below the national average, while wages for Health Care Support jobs were slightly higher than the national average. Overall average wage growth from 2003 to 2010 outpaced national wage growth.[32]
- Table 3 compares the percent change in employment and wages for health care occupations and all occupations at both the state and national level, from 2003 to 2010. Wyoming exceeded national averages in wage increases for all occupations and health care occupations as displayed in Table 3.

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[24] U.S. Census Bureau, *State and County Quick Facts*. Available online: http://quickfacts.census.gov/qfd/states/56000.html
[25] Wyoming Department of Administration and Information, Economic Analysis Division, *Wyoming's Population Experiences its Fastest Decennial Growth Since 1980* (December 21, 2010). Available online: http://cityofdouglaswy.com/vertical/Sites/%7B52347BB1-2476-45A1-A80E-FDF4BD158A35%7D/uploads/%7B14B686EC-A8E2-4CCA-A3B9-7B715AA53926%7D.PDF
[26] U.S. Census Bureau, *Profile of General Population and Housing Characteristics:* (2010). Available online: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
[27] Wingspan, *Young, stable but Wyoming still least populated state* (2011). Available online: http://wingspan.lccc.wy.edu/issues/Feb11/News/wyomingPopulation.html
[28] U.S. Census Bureau, *State and County Quick Facts*. Available online: http://quickfacts.census.gov/qfd/states/56000.html
[29] U.S. Census Bureau, *State and County Quick Facts*. Available online: http://quickfacts.census.gov/qfd/states/56000.html
[30] State Auditor, Wyoming, *A Wyoming Financial Perspective* (2009). Available online: http://sao.state.wy.us/CAFR/2009_Report/PopularReportfy09.pdf
[31] Bureau of Labor Statistics, *May 2010 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm
[32] Bureau of Labor Statistics, *May 2010 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm

Additionally, Wyoming exceeded national averages for employment growth for all occupations and health care support workers.[33] Further, Table 3 shows that employment in the health care sector continued to increase faster than overall employment growth during the same period, both nationally and in Wyoming.

Table 3: Total Percent Increase in U.S. and Wyoming Employment and Wage Increases, 2003 to 2010

	Employment Total Percent Increase from 2003 to 2010		Wages Total Percent Increase from 2003 to 2010	
	US	WY	US	WY
All Occupations	-0.4%	12.1%	22.7%	33.1%
Health Care Practitioners and Technical Occupations	19.0%	25.2%	28.7%	34.6%
Health Care Support Workers	23.5%	17.0%	18.3%	35.9%

- Table 4 shows the U.S. Bureau of Labor Statistics Wyoming-specific annual wage increases over the prior year for 2003 to 2010.

Table 4: Wyoming Annual Percent Wage Increase from Prior Year, 2003 to 2010

	2003 (change from 2002)	2004 (change from 2003)	2005 (change from 2004)	2006 (change from 2005)	2007 (change from 2006)	2008 (change from 2007)	2009 (change from 2008)	2010 (change from 2009)
All Occupations	1.8%	3.1%	2.4%	4.1%	5.3%	5.7%	4.6%	4.0%
Health Care Practitioners and Technical Occupations	2.6%	9.2%	0.1%	2.8%	6.8%	2.6%	7.2%	2.0%
Health Care Support Workers	1.5%	5.0%	4.7%	2.4%	5.7%	4.9%	6.4%	2.4%

Conclusion

- Wyoming has a history of strong state budget performance. Due to the revenue generated from Wyoming's mineral resources, combined with the state's restrained spending, Wyoming ended SFY 2011 with a budget surplus. Additionally, Wyoming is one of 11 states with the top credit rating from Standard & Poor's, which recognized the state for its "conservative budgeting and forecasting practices."[34] As Wyoming prepares for the implementation of health care reform and future changes to the Medicaid program, Wyoming state government is well-positioned to manage the budget challenges of the next biennium.

[33] Bureau of Labor Statistics, *May 2010 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm
[34] Bloomberg, *Wyoming Boosted to Highest Credit Rating by S&P to Join 11 States at AAA* (May 2011). Available at: http://www.bloomberg.com/news/2011-05-03/wyoming-s-issuer-credit-rating-is-raised-to-aaa-by-s-p-with-stable-outlook.html

Medicaid Services Overview

Table 1: Service Areas Included in SFY 2011 Annual Report

Included Service Areas	
Ambulance	Laboratory
Ambulatory Surgery Center (ASC)	Behavioral Health[35]
Comprehensive Outpatient Facility (CORF)	Nursing Facilities[36]
Dental	Psychiatric Residential Treatment Facility(PRTF)
Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS)	Physician and Other Practitioners
End State Renal Disease (ESRD)	Prescription Drug
Federally Qualified Health Center (FQHC)	Radiology
Home Health	Rural Health Clinic (RHC)
Hospice	Vision
Hospital[37]	Waiver Services[38]
Interpreter Services	Other Services[39]

[35] Includes behavioral health services provided by behavioral health professionals. See Waiver Services section for Children's Mental Health Waiver and the Psychiatric Residential Treatment Facility section for PRTF services.
[36] Does not include long-term care or assisted living facility waiver services, see Waiver Services section.
[37] Includes inpatient and outpatient hospital services.
[38] Includes waiver programs: Adult and Child Developmental Disabilities Waivers, Acquired Brain Injury, Long-Term Care, Assisted Living Facility, Children's Mental Health, and Pregnant by Choice.
[39] Other services comprise of services that were out of the criteria ranges.

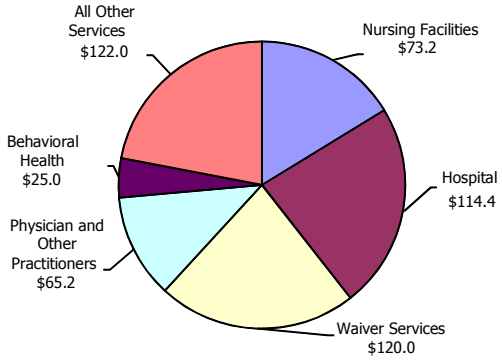
Table 2: Mandatory and Optional Services

Mandatory Services	Optional Services
Physician	Dental
Rural Health Clinic (RHC)	Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
Laboratory and x-ray	End stage renal disease (ESRD)
Nurse-midwife	Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
Inpatient and outpatient hospital	Interpreter services
Certified pediatric nurse practitioner or family nurse practitioner	Mental health and substance abuse
Nursing facility	Prescription drugs
Early and periodic screening, diagnostic, and treatment (EPSDT)[40]	Psychiatric Residential Treatment Facility (PRTF)
Home health care	Targeted case management
Family planning and supplies	Vision
Transportation[41]	Waiver services
Federally Qualified Health Center (FQHC)	

Expenditure Overview

- Expenditures for all Medicaid services increased 1 percent from SFY 2010 to SFY 2011.

Figure 1: Medicaid Expenditures – SFY 2011 (millions)



[40] Medicaid operates the Health Check program as EPSDT.
[41] Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

SECTION 4: MEDICAID SERVICES & EXPENDITURES

Table 1: Percentage Change in Total Expenditures for Service Areas – SFYs 2010-2011, Arrayed by SFY 2011 Expenditures

Service Area	SFY 2010 Expenditures	SFY 2011 Expenditures	Percentage Change from SFY 2010
Waiver Services[42]	113,325,317	$ 120,049,329	6
Adult DD Waiver	75,746,359	81,369,215	7
Child DD Waiver	14,460,017	14,128,741	-2
LTC Waiver	13,424,332	13,912,032	4
ABI Waiver	6,243,946	6,963,271	12
ALF Waiver	3,058,800	2,757,617	-10
Children's Mental Health Waiver	391,862	918,455	134
Hospital[43]	113,641,274	114,357,604	1
Inpatient	87,297,343	84,557,214	-3
Outpatient	26,267,488	29,691,724	13
Nursing Facilities	75,434,811	73,180,333	-3
Physician and Other Practitioners[44]	65,301,194	65,168,221	0
Prescription Drugs	38,750,658	41,330,767	7
Behavioral Health[45]	22,884,970	24,927,506	9
PRTF	14,658,731	15,244,613	4
Dental	12,864,308	13,616,583	6
DMEPOS	6,605,716	7,505,683	14
Ambulance	3,807,538	3,303,240	-13
Vision	3,251,155	3,286,215	1
FQHC	2,864,956	3,103,164	8
ASC	3,315,928	2,912,791	-12
Home Health	1,941,097	2,732,905	41
RHC	1,710,855	1,940,640	13
Laboratory	1,121,964	1,171,185	4
Hospice	1,432,471	1,036,887	-28
ESRD	1,160,798	835,621	-28

[42] The Pregnant by Choice Waiver expenditures were $106,300 for SFY 2011 and were excluded from this table because they were included in the expenditures for other service areas. See the Pregnant by Choice Waiver section for more information.
[43] The expenditures for inpatient and outpatient hospital services exclude QRA payments made to providers in SFY 2011. See the Hospital sections for more information on QRA payments. Total hospital expenditures include adjustments that could be either inpatient or outpatient.
[44] The physician data includes expenditures for behavioral health services provided by non-behavioral health professionals, which are approximately $1.7 million in SFY 2010 and $1.5 million in SFY 2011. See the Behavioral Health section for more information.
[45] Includes behavioral health services provided by behavioral health professionals.

Service Area	SFY 2010 Expenditures	SFY 2011 Expenditures	Percentage Change from SFY 2010
Mobile Radiology	222,281	217,463	-2
CORF	36,757	56,646	54
Interpreter Services	47,837	54,259	13
Other Services[46]	30,148,706	23,572,623	-22
Total	**$ 514,529,323**	**$ 519,604,279**	**6**

Table 2: Expenditures of Other Services Category

Provider Taxonomy Code and Description		SFY 2011 Expenditures
	Unknown	$ 21,733
111N00000X	Chiropractor	6,102
246RP1900X	Phlebotomy/WY Health Fair	3,820
251B00000X	Case Management	299,616
251C00000X	Day Training, Developmentally Disabled Service	222,425
251K00000X	Public Health Or Welfare	1,093,397
261Q00000X	Clinic/Center	1,496,903
261QA0005X	Ambulatory Family Planning Facility	83,744
261QP0904X	Public Health, Federal	8,532,271
315P00000X	Intermediate Care Facility, Mentally Retarded	11,388,412
322D00000X	Residential Treatment Facility, Emotionally Disturbed Children	424,200
Total Other Services		**$ 23,572,623**

Recipient Overview

- From SFY 2010 to SFY 2011, the number of recipients increased for all but the shaded service areas shown in Table 1. The largest percentage increase in recipients occurred for comprehensive outpatient rehabilitation facilities (CORF) and the Children's Mental Health Waiver; however, the number of recipients these increases represent is relatively small.

[46] Other services comprise of services that were out of the criteria ranges.

SECTION 4: MEDICAID SERVICES & EXPENDITURES

Table 1: Number of Medicaid Recipients by Service Area in SFY 2011 and Percentage Change from SFY 2010, Arrayed by Number of Recipients[47]

Service Area	Number of Recipients SFY 2011	Percentage Change from SFY 2010
Physician and Other Practitioners	65,060	2
Prescription Drugs	50,131	2
Hospital	43,940	1
Outpatient	*41,348*	*1*
Inpatient	*11,745*	*-4*
Dental	28,293	7
Vision	14,700	3
Behavioral Health[48]	10,529	7
Laboratory	9,956	1
DMEPOS	7,526	1
RHC	5,539	19
FQHC	4,855	18
Waiver Services[49]	4,493	1
LTC Waiver	*1,809*	*-1*
Adult DD Waiver	*1,355*	*1*
Child DD Waiver	*799*	*-1*
ALF Waiver	*217*	*-8*
ABI Waiver	*177*	*-8*
Children's Mental Health Waiver	*136*	*77*
Ambulance	3,659	9
ASC	3,161	3
Nursing Facilities	2,460	-6
Home Health	623	6
Mobile Radiology	557	10
Interpreter Services	420	9
PRTF	404	-8
Hospice	150	2
CORF	147	81
ESRD	86	4
Other Services[50]	14,412	14

[47] The table displays a distinct count of recipients for each service area. This table does not include a total number of recipients because individuals may receive services from multiple service areas. Therefore, summing the number of recipients would have the inadvertent effect of "double counting" individuals if they received more than one service.
[48] Includes behavioral health services provided by behavioral health professionals.
[49] There were 425 Pregnant by Choice Waiver recipients in SFY 2011 who were excluded from this table because they were captured in other service areas. See the Pregnant by Choice Waiver section for more information.
[50] Other services comprise of services that were out of the criteria ranges.

Expenditures per Recipient and Eligible

Table 1: Percentage Change in Expenditures per Recipient – SFYs 2010-2011, Arrayed by Expenditures per Recipient

Service Area	SFY 2011 Expenditures Per Recipient	Percentage Change from SFY 2010
PRTF	$ 37,734	13
Nursing Facilities	29,748	3
Waiver Services[51]	26,719	5
Adult DD Waiver	60,051	6
ABI Waiver	39,341	21
Child DD Waiver	17,683	-2
ALF Waiver	12,708	-2
LTC Waiver	7,690	4
Children's Mental Health Waiver	6,753	33
ESRD	9,717	-31
Hospice	6,913	-29
Home Health	4,387	33
Hospital	2,603	<1
Inpatient	7,199	1
Outpatient	718	12
Behavioral Health[52]	2,368	1
Physician and Other Practitioners	1,002	-2
DMEPOS	997	12
ASC	921	-15
Ambulance	903	-20
Prescription Drugs	824	4
FQHC	639	-8
Dental	481	-1
Mobile Radiology	390	-11
CORF	385	-15
RHC	350	-4
Vision	224	-1
Interpreter Services	129	4
Laboratory	118	3
Other Services[53]	1,636	-31

[51] Pregnant by Choice Waiver expenditures per recipient in SFY 2011 were $250 and were excluded from this table because they were included in the expenditures for other service areas. See the Pregnant by Choice Waiver section for more information.
[52] Includes behavioral health services provided by behavioral health professionals.
[53] Other services comprise of services that were out of the criteria ranges.

Table 2: Percentage Change in Expenditures per Eligible Individual by Service Area – SFYs 2010-2011, Arrayed by Expenditures per Eligible Individual

Service Area	SFY 2011 Expenditures Per Eligible Individual	Percentage Change from SFY 2010
Waiver Services	$ 1,726	5
Adult DD Waiver	1,170	7
Child DD Waiver	203	-3
LTC Waiver	200	3
ABI Waiver	100	11
ALF Waiver	40	-11
Children's Mental Health Waiver	13	133
Hospital	1,644	0
Inpatient	1,216	-4
Outpatient	427	12
Nursing Facilities	1,052	-4
Physician and Other Practitioners	937	-1
Prescription Drugs	594	6
Behavioral Health[54]	358	8
PRTF	219	3
Dental	196	5
DMEPOS	108	13
Ambulance	47	-14
Vision	47	< 1
FQHC	45	7
ASC	42	-13
Home Health	39	40
RHC	28	13
Laboratory	17	4
Hospice	15	-28
ESRD	12	-29
Mobile Radiology	3	-3
CORF	1	53
Interpreter Services	1	13
Other Services[55]	339	-22

[54] Includes behavioral health services provided by behavioral health professionals.
[55] Other services comprise of services that were out of the criteria ranges.

Medicaid and Medicare Dual Individuals

- For some services, Medicare is the primary payer and Medicaid provides additional payments; claims for these services are referred to as crossover claims. Other services for this population are funded entirely through Medicaid, because Medicare does not cover all services.
- The data includes expenditures for both crossover claims for dually eligible individuals and Medicaid-only funded services for dually eligible individuals, and excludes premium assistance for QMB, SLMB-1 and SLMB-2 individuals because these expenditures are considered administrative expenditures.
- The SFY 2011 expenditures for crossover claims were approximately $14.8 million. The expenditures for Medicaid-only funded services for dually eligible individuals are presented in this section as well as in other sections of this Report.
- Overall expenditures for dual eligible individuals were $180 million in SFY 2011, an increase of 3 percent from $175.4 million in SFY 2010.
- Expenditures per recipient remained approximately the same; $4,578 in SFY 2010 and $4,564 in SFY 2011.
- Eighty-one percent of all expenditures were represented by two service areas: waiver services and nursing facilities.
- Most dually eligible recipients received hospital services, physician or other practitioners and prescription drug services in SFY 2011.
- The highest expenditures per dually eligible recipient in SFY 2011 occurred with nursing facilities and waiver services, where the expenditures per recipient were $31,088, and $27,787, respectively.

Table 1: Dual Expenditures by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Expenditures

Service Area	Expenditures SFY 2010	Expenditures SFY 2011	Percent Change from SFY 2010
Waiver Services	$ 70,920,710	$ 75,496,372	6
Adult DD Waiver	*51,483,653*	*55,414,008*	*8*
LTC Waiver	*11,081,813*	*11,497,114*	*4*
ABI Waiver	*4,909,576*	*5,581,725*	*14*
ALF Waiver	*2,971,930*	*2,682,087*	*-10*
Child DD Waiver	*473,737*	*305,746*	*-35*
Children's Mental Health Waiver	*No Expenditures*	*15,693*	*NA*
Nursing Facilities	71,301,451	69,574,434	-2
Hospital[56]	7,731,875	8,021,930	4
Outpatient	*3,545,229*	*4,099,109*	*16*
Inpatient	*4,197,470*	*3,855,819*	*-8*
Physicians and Other Practitioners	3,992,752	4,363,618	9
Behavioral Health[57]	3,810,691	3,836,816	1
DMEPOS	2,034,746	2,319,115	14
Prescription Drugs	1,495,589	1,656,563	11
Home Health	860,553	1,352,392	57
Dental	848,037	941,067	11
Hospice	1,029,292	790,008	-23
ESRD	459,084	327,604	-29
Ambulance	281,621	297,016	5
FQHC	212,875	256,017	20
ASC	139,508	162,664	17
RHC	129,660	144,828	12
Vision	78,498	87,021	11
Laboratory	38,874	39,502	2
Mobile Radiology	18,617	35,643	91
CORF	5,315	9,352	76
Interpreter Services	3,476	No Expenditures	NA
PRTF	No Expenditures	No Expenditures	NA
Other Services[58]	10,039,789	10,407,723	4
Total	**$175,433,011**	**$180,119,686**	**3**

[56] Total hospital expenditures include adjustments that could be either inpatient or outpatient.
[57] Includes behavioral health services provided by behavioral health professionals.
[58] Other services comprise of services that were out of the criteria ranges.

Table 2: Dual Recipients by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Recipients

Service Area	Recipients SFY 2010	Recipients SFY 2011	Percent Change from SFY 2010
Hospital	6,252	6,421	3
Outpatient	*6,063*	*6,272*	*3*
Inpatient	*2,014*	*1,966*	*-2*
Physicians and Other Practitioners	7,445	7,654	3
Prescription Drugs	3,131	3,222	3
DMEPOS	2,986	3,130	5
Waiver Services	2,737	2,717	-1
LTC Waiver	*1,455*	*1,446*	*-1*
Adult DD Waiver	*900*	*904*	*0*
ALF Waiver	*223*	*209*	*-6*
ABI Waiver	*140*	*138*	*-1*
Child DD Waiver	*19*	*18*	*-5*
Children's Mental Health Waiver	*No Recipients*	*2*	*NA*
Nursing Facilities	2,318	2,238	-3
Laboratory	1,961	1,973	1
Behavioral Health[59]	1,676	1,788	7
Dental	1,482	1,636	10
Vision	1,507	1,605	7
Ambulance	971	1,153	19
FQHC	828	869	5
RHC	800	839	5
ASC	576	607	5
Home Health	176	231	31
Mobile Radiology	163	200	23
Hospice	77	77	0
ESRD	71	70	-1
CORF	24	38	58
Interpreter Services	1	No Recipients	NA
PRTF[60]	No Recipients	No Recipients	NA
Other Services[61]	3,136	2,997	-4

[59] Includes behavioral health services provided by behavioral health professionals.
[60] Recipients received medical and/or therapy court order placement services.
[61] Other services comprise of services that were out of the criteria ranges.

Table 3: Dual Expenditures per Recipient by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Expenditures per Recipient

Service Area	Expenditures Per Recipient SFY 2010	Expenditures Per Recipient SFY 2011	Percent Change from SFY 2010
Nursing Facilities	$ 30,760	$ 31,088	1
Waiver Services	25,912	27,787	7
Adult DD Waiver	57,204	61,299	7
ABI Waiver	35,068	40,447	15
Child DD Waiver	24,934	16,986	-32
ALF Waiver	13,327	12,833	-4
LTC Waiver	7,616	7,951	4
Children's Mental Health Waiver	No Expenditures	7,847	NA
Hospice	13,367	10,260	-23
Home Health	4,890	5,855	20
ESRD	6,466	4,680	-28
Behavioral Health[62]	2,274	2,146	-6
Hospital	1,237	1,249	1
Inpatient	2,084	1,961	-6
Outpatient	585	654	12
DMEPOS	681	741	9
Dental	572	575	1
Physicians and Other Practitioners	536	570	6
Prescription Drugs	478	514	8
FQHC	257	295	15
ASC	242	268	11
Ambulance	290	258	-11
CORF	221	246	11
Mobile Radiology	114	178	56
RHC	162	173	7
Vision	52	54	4
Laboratory	20	20	1
Interpreter Services	3,476	No Expenditures	NA
PRTF	No Expenditures	No Expenditures	NA
Other Services[63]	3,201	3,473	8

[62] Includes behavioral health services provided by behavioral health professionals.
[63] Other services comprise of services that were out of the criteria ranges.

Foster Care

- Total Medicaid healthcare expenditures for foster care children decreased 20 percent from approximately $28.9 million in SFY 2010 to $23.0 million in SFY 2011, while State-only healthcare expenditures for this group decreased by 22 percent from $2.0 million in SFY 2010 to $1.6 million in SFY 2011.

Medicaid Foster Care Expenditures

- Total Medicaid healthcare expenditures for foster care children were $23 million in SFY 2011, a decrease of 20 percent from SFY 2010. Medicaid foster care expenditures were 13 percent of total Medicaid expenditures.
- Medicaid healthcare expenditures per foster care recipient decreased by 22 percent from $8,836 in SFY 2010 to $6,855 in SFY 2011.
- In SFY 2011, expenditures for behavioral health and PRTF services totaled $14.1 million or 61 percent of healthcare expenditures for foster care children.[64] Prescription drug and hospital expenditures represent $3.2 million and $2 million, respectively, which accounts for 14 and 9 percent of total Medicaid foster care expenditures. Healthcare expenditures for two of the largest service areas, PRTF and hospital, decreased 45 percent and 22 percent, respectively, from SFY 2010 to 2011.
- The healthcare expenditures associated with CORF, home health services, waiver services and mobile radiology services each have fewer than 10 recipients and thus have wide fluctuations in expenditures from year to year.
- CORF expenditures increased by 297 percent based on an increase of $5,400 in expenditures and a recipient count that increased from 4 to 9 individuals.
- Expenditures for home health services decreased 91 percent from SFY 2010 to 2011, but these expenditures were for a relatively small percent of total Medicaid foster care expenditures.
- Expenditures per recipient for DMEPOS increased 58 percent and home health expenditures per recipient decreased 86 percent from SFY 2010 to SFY 2011.

[64] Includes services provided by PRTFs and behavioral health professionals.

Table 1: Healthcare Expenditures for Medicaid-Funded Foster Care by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Expenditures

Service Area	Expenditures SFY 2010	Expenditures SFY 2011	Percent Change from SFY 2010
PRTF	$ 14,179,764	$ 7,826,952	-45
Behavioral Health	5,501,561	6,272,494	14
Prescription Drugs	3,004,591	3,156,912	5
Hospital[65]	2,567,341	2,002,228	-22
Inpatient	*1,893,692*	*1,368,399*	*-28*
Outpatient	*673,653*	*634,036*	*-6*
Physicians & Other Practitioners	1,622,756	1,602,312	-1
Dental	782,598	775,467	-1
Vision	298,224	304,750	2
DMEPOS	76,482	116,301	52
ASC	107,999	109,855	2
RHC	81,159	100,547	24
FQHC	100,969	98,434	-3
Ambulance	97,941	83,516	-15
Laboratory	31,948	27,294	-15
ESRD	No Expenditures	18,132	NA
CORF	1,812	7,191	297
Mobile Radiology	6,304	3,177	-50
Home Health	25,641	2,366	-91
Waiver Services	1,752	1,632	-7
Other Services[66]	369,357	447,448	21
Total Expenditures	**28,858,199**	**22,957,008**	**-20**

[65] Total hospital expenditures include adjustments that could be either inpatient or outpatient.
[66] Other services comprise of services that were out of the criteria ranges.

Table 2: Healthcare Expenditures per Medicaid-Funded Foster Care Recipient by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Expenditures per Recipient

Service Area	Expenditures per Recipient SFY 2010	Expenditures per Recipient SFY 2011	Percent Change from SFY 2010
PRTF	$ 30,960	$ 36,404	18
Behavioral Health	3,316	3,770	14
Prescription Drugs	1,350	1,402	4
Hospital	1,691	1,393	-18
Inpatient	*10,348*	*8,661*	*-16*
Outpatient	*460*	*453*	*-2*
ASC	1,049	1,046	0
CORF	453	799	76
Ambulance	899	773	-14
DMEPOS	487	770	58
Physicians & Other Practitioners	640	632	-1
Home Health	4,273	592	-86
FQHC	526	547	4
Dental	466	449	-4
Mobile Radiology	573	397	-31
RHC	376	378	1
Waiver Services	146	272	86
Vision	265	261	-2
Laboratory	101	93	-8
ESRD	No Expenditures	18,132	NA
Other Services[67]	716	669	-7

[67] Other services comprise of services that were out of the criteria ranges.

State Funded Foster Care Expenditures

- Total State-only healthcare expenditures for foster care children were $1.6 million in SFY 2011, a decrease of 22 percent from SFY 2010.
- Expenditures per recipient decreased by 19 percent from $5,984 in SFY 2010 to $4,876 in SFY 2011.
- The largest component of healthcare expenditures was expenditures for behavioral health services, which accounted for 60 percent of state foster care healthcare expenditures in SFY 2011.
- Expenditures for most other service areas, like RHC, FQHC and DMEPOS, have decreased considerably from SFY 2010 to SFY 2011; however, expenditures for these areas were relatively small as a percentage of total State-only funded foster care healthcare expenditures.

Table 3: State-funded Foster Care Healthcare Expenditures by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Expenditures

Service Area	Expenditures SFY 2010	Expenditures SFY 2011	Percent Change from SFY 2010
Behavioral Health	$ 1,023,598	$ 963,417	-6
Prescription Drugs	144,671	168,718	17
Hospital[68]	111,714	136,786	22
Inpatient	*70,682*	*97,779*	*38*
Outpatient	*39,832*	*39,007*	*-2*
PRTF	536,515	124,749	-77
Dental	119,490	92,269	-23
Physicians & Other Practitioners	69,730	69,640	0
Vision	28,066	28,362	1
Laboratory	1,558	1,988	28
Ambulance	1,343	1,764	31
FQHC	5,685	1,621	-71
RHC	1,700	1,131	-33
DMEPOS	916	358	-61
Waiver Services	No Expenditures	296	NA
CORF	395	No Expenditures	NA
ASC	2,391	No Expenditures	NA
ESRD	No Expenditures	No Expenditures	NA
Home Health	No Expenditures	No Expenditures	NA
Mobile Radiology	No Expenditures	No Expenditures	NA
Other Services[69]	4,764	8,309	74
Total Expenditures	**2,052,536**	**1,599,409**	**-22**

[68] Total hospital expenditures include adjustments that could be either inpatient or outpatient.
[69] Other services comprise of services that were out of the criteria ranges.

Table 4: Healthcare Expenditures per State-funded Foster Care Recipient by Service Area — SFYs 2010-2011, Arrayed by SFY 2011 Medical Expenditures per Recipient

Service Area	Expenditures per Recipient SFY 2010	Expenditures per Recipient SFY 2011	Percent Change from SFY 2010
PRTF	26,826	13,861	-48
Behavioral Health	3,579	3,466	-3
Hospital	901	1,290	43
Inpatient	*7,068*	*9,778*	*38*
Outpatient	*338*	*386*	*14*
Prescription Drugs	637	852	34
Dental	613	580	-5
Physicians & Other Practitioners	363	449	24
Waiver Services	No Expenditures	296	NA
Vision	242	270	12
Ambulance	336	252	-25
FQHC	711	203	-71
RHC	283	141	-50
Laboratory	87	110	28
DMEPOS	229	90	-61
CORF	132	No Expenditures	NA
ASC	1,196	No Expenditures	NA
ESRD	No Expenditures	No Expenditures	NA
Home Health	No Expenditures	No Expenditures	NA
Mobile Radiology	No Expenditures	No Expenditures	NA
Other Services[70]	53	134	153

[70] Other services comprise of services that were out of the criteria ranges.

Ambulance

- Ambulance services comprise emergency ground and air transportation and limited non-emergency ground transportation.
- Total ambulance expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Total Ambulance Services: Expenditures and Recipients by SFY

State Fiscal Year[71]	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 2,831,992	3,278	$ 864
2009	4,327,795	3,522	1,229
2010	3,807,538	3,367	1,131
2011	3,303,240	3,659	903
Percent Change SFYs 2010-2011	-13.0	8.7	-20.2

Table 2: Ground Ambulance Only Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,216,394	4,568	$ 266
2009	1,456,553	4,825	302
2010	1,371,166	4,328	317
2011	1,354,172	4,718	287
Percent Change SFYs 2010-2011	-1.0	9.0	-9.4

[71] Total ambulance expenditures include adjustment that could not be determined to be ground or air.

Table 3: Air Ambulance Only Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,615,532	496	$ 3,257
2009	2,868,883	574	4,998
2010	2,436,251	536	4,545
2011	1,946,504	499	3,901
Percent Change SFYs 2010-2011	-20.0	-6.9	-14.2

Highlights and Developments

- Medicaid will continue to review policy in comparison to Medicare and The Office of Emergency Medical Services policies and make appropriate changes.
- Medicaid will review current rates to assess whether Medicaid rates fall below Medicare rates and to determine the need for further changes.

Reimbursement Methodology

- Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for ambulance services.
- Medicaid established a fixed fee schedule amount for transport and makes separate payments for mileage and disposable supplies.
- There are separate fee schedules for basic life support (ground), advanced life support (ground), additional advanced life support (ground) and air ambulance.
- Medicaid payments as a percent of billed charges were 25 percent in SFY 2010 as compared to 20 percent in SFY 2011.

ASC

- Services provided by freestanding Ambulatory Surgery Centers (ASC) are those that do not require overnight inpatient hospital care. These services encompass all surgical procedures covered by Medicare and additional surgical procedures that Medicaid approves for provision as outpatient services. ASCs provide services that can also be provided in an outpatient hospital setting.

- Total outpatient hospital and ASC expenditures was $32.6 million in SFY 2011, an increase of 10 percent from $29.6 million in SFY 2010.[72]
- ASC expenditures made up 11 percent of the outpatient hospital and ASC expenditures in SFY 2010 and 9 percent in SFY 2011.
- ASC expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: ASC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 2,111,044	2,493	$ 847
2009	3,497,383	3,217	1,087
2010	3,315,928	3,075	1,078
2011	2,912,791	3,161	921
Percent Change SFYs 2010-2011	-12.2	2.8	-14.5

[72] Outpatient expenditures do not include Qualified Rate Adjustment (QRA) payments.

Table 2: ASC SFY 2011 Expenditures and Rates by ASC Grouping[73]

ASC Grouping	SFY 2011 Expenditures ($)	Percent of Total ASC Expenditures	Calendar Year 2011 Rate
Group 1	$ 142,455	5	$ 300
Group 2	234,339	8	401
Group 3	461,494	16	459
Group 4	147,090	5	567
Group 5	63,481	2	645
Group 6	572	<1	743
Group 7	47,588	2	896
Group 8	71,630	2	876
Group Y Misc.[74]	1,736,509	60	70% of billed charges
Group Z	2,256	<1	
Unknown	4,410	<1	

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid pays the lower of the provider's usual and customary charge or the Medicaid fee schedule for services provided in ASCs.
- Beginning in 2008, CMS implemented a revised Medicare reimbursement methodology to more closely align ASC payments with the outpatient prospective payment system (OPPS). The new methodology reduced payments to ASCs to take into account the lower cost of providing services in an ASC setting. CMS is implementing this change over a four-year transition period. Since these changes were implemented, Medicare no longer maintains a current ASC grouping methodology; as a result, when an ASC bills a service that is not already assigned to one of the other eight ASC groups, Medicaid reviews the code and puts it into a separate ASC group. If the Department determines the service to be valid for an ASC, Medicaid pays 70 percent of charges for the service.
- Medicaid considered adopting Medicare's methodology; however, it was determined that it was not a viable option at this time. This may be revisited in the future.
- Medicaid payments as a percent of billed charges were 27 percent in SFY 2010 as compared to 23 percent in SFY 2011.

[73] There are additional procedure codes in the ASC groups in SFY 2011. Also, procedure code 41899 (dental surgery procedure) is classified in Group Y in SFY 2011.
[74] The expenditures in the Group Y Misc. row of Table 1 represent expenditures for procedure codes that do not fall into ASC groups 1 through 8. Medicaid reviews these procedure codes and pays them at a percentage of billed charges. Procedure code 41899 represents 100 percent of Group Y expenditures in SFY 2011. Effective April 1, 2011 the 41899 payment was reduced from 80% to 70%.

Behavioral Health

- Behavioral Health services include covered services provided by Community Mental Health Centers (CMHCs) and Substance Abuse Service Centers (SACs), Licensed Mental Health and Substance Abuse Treatment providers.
- Medicaid covers medically necessary psychiatric services provided by a physician (including psychiatrists), or when provided by other behavioral health practitioners who work under a physician, including:
    - Masters level counselors (e.g., Licensed Addictions Therapist (LAT), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW))
    - Physician assistants
- Medicaid also reimburses independently practicing clinical psychologists and the mental health practitioners who work under the supervision of a clinical psychologist. Advanced practice and psychiatric mental health nurse practitioners are also enrolled and reimbursed independently for the covered services they provide.
- Behavioral health services provided by CMHCs include mental health assessments, individual and group therapy, rehabilitation services, peer specialists services, and case management.
- Medicaid also covers psychiatric residential treatment for individuals under age 21 in a PRTF. Behavioral health services provided in a PRTF are included in the non-behavioral health providers providing behavioral health services.
- Behavioral health hospital expenditures are discussed in the Hospital section of this Report and the Children's Mental Health Waiver services are discussed in the Waiver Services section of this Report.
- Behavioral health expenditures provided by psychiatrists are unique to this section of this Report, while the behavioral health expenditures provided by non-behavioral health professionals presented here are also presented elsewhere in this Report.
- Mental health services are also provided by the Wyoming State Hospital and Wyoming Behavioral Institute – the State's two psychiatric hospitals. Expenditures for the Wyoming State Hospital are included in the non-behavioral health providers providing behavioral health services. The Wyoming State Hospital admits patients who are considered to be a danger to themselves or others pursuant to Wyoming Statute on involuntary hospitalization; patients who are psychiatrically and medically fragile; or persons whom the legal system placed in the hospital after it classified them as not competent to stand trial, or guilty of committing crimes due to mental illness.[75] Wyoming Behavioral Institute inpatient hospital expenditures are included in the non-behavioral health providers providing behavioral health services as well as the Hospital section of this Report.
- In SFY 2011, CMHCs accounted for 40 percent of behavioral health expenditures.
- An analysis of claims by primary diagnoses code indicates that claims with the top five diagnosis codes (determined by expenditures) accounted for 29 percent of expenditures for behavioral health professionals.
- Behavioral health expenditures were five percent of total Medicaid expenditures in SFY 2011.

[75] W.S. 25-10-101(a)(ii)

Table 1: Behavioral Health Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 17,433,390	8,421	$ 2,070
2009	18,938,708	9,061	2,090
2010	22,884,970	9,795	2,336
2011	24,927,506	10,529	2,368
Percent Change SFYs 2010-2011	8.9	7.5	1.3

Table 2: Non-Behavioral Health Providers Providing Behavioral Health Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,873,818	2,323	$ 807
2009	2,168,943	2,738	792
2010	1,717,367	3,564	482
2011	1,551,177	3,773	411
Percent Change SFYs 2010-2011	-9.7	5.9	-14.7

Table 3: Behavioral Health Services: Expenditures by Provider Type – SFY 2011

Provider Type	Provider Description	Number of Providers	Expenditures
261QM0801X	Mental Health-Including Community Mental Health	27	$ 9,911,967.21
103TC0700X	Clinical Psychologist	72	7,780,854.20
2084P0800X	Psychiatry And Neurology, Psychiatry	38	4,818,845.13
261QR0405X	Rehabilitation, Substance Use Disorder	27	2,172,581.42
364SP0808X	Advance Practice Nurse	6	203,063.05
101YP2500X	Professional Counselor	8	40,194.66
Total		**178**	**24,927,506**

Table 4: Top Five Diagnoses Codes by Expenditures – SFY 2011

Diagnosis Code Description	Code	Recipient Age	Expenditures
Depressive Disorder, Not Elsewhere Classified	311	0-20	$ 1,460,501
		21-64	781,027
		65+	63,775
Unspecified Adjustment Reaction	309.9	0-20	1,356,979
		21-64	172,520
		65+	6,362
Attention Deficit Disorder of Childhood	314.01	0-20	1,193,306
		21-64	28,004
		65+	0
Posttraumatic Stress Disorder	309.81	0-20	705,117
		21-64	444,031
		65+	17,810
Oppositional Defiant Disorder	313.81	0-20	1,111,769
		21-64	6,391
		65+	0
Total Expenditures for Top Five Codes		**0-20**	**5,827,672**
		21-64	**1,431,973**
		65+	**87,948**

Table 5: Non-Behavioral Health Providers Providing Behavioral Health Services: Expenditures by Provider Type – SFY 2011

Provider Type	Provider Description	Number of Providers	Expenditures
207Q00000X	Family Practice	14	$ 516,383
208D00000X	Physician, General Practice	22	416,165
322D00000X	Residential Treatment Facility, Emotionally Disturbed Children	2	233,921
208000000X	Pediatrics	13	207,937
207R00000X	Internal Medicine	4	59,983
2084N0400X	Psychiatry And Neurology: Neurology	10	34,468
363LP0200X	Pediatrics	1	21,549
261Q00000X	Clinic/Center	3	17,945
152W00000X	Optometrist	7	16,530
207T00000X	Neurological Surgery	2	14,156
363L00000X	Nurse Practitioner	1	8,230
363LX0001X	Obstetrics And Gynecology	1	2,140
261QP0904X	Public Health, Federal	1	1,545
207L00000X	Anesthesiology	1	329
208100000X	Physical Medicine And Rehabilitation	1	321
235Z00000X	Speech-Language Pathologist	1	38
Total		**85**	**1,551,177**

Highlights and Developments

- Due to the aging of the Wyoming population, Medicaid reports that there is a growing need for geriatric psychiatric services in Wyoming and a lack of appropriately trained providers in the State.
- The Wyoming Planning Team for At Risk Children, an executive level group formed to enhance collaboration and communication on issues concerning at-risk children and youth, have continued to collaborate and share resources among child-serving agencies to further development of Wyoming's children's behavioral health system of care.
- Wyoming successfully submitted and was approved for a five year grant to support a project through which Wyoming will implement a Care Management Entity (CME) provider model using High Fidelity Wraparound to improve the quality and cost of care for Medicaid and CHIP children with serious behavioral health disorders. SFY 2011 CHIPRA activities include developing a Medicaid behavioral health services rate to be utilized by the CME.

- Ongoing efforts to further develop the children's behavioral health system of care during SFY11 included state wide training on: Wyoming's High Fidelity Wraparound initiative; and, train-the trainer and evaluator training on the use of the American Academy of Child & Adolescent Psychiatrist's (AACAP) Child and Adolescent Service Intensity Instrument (CASII) and the Early Childhood Service Intensity Instrument (ECSII).

Reimbursement Methodology

- Medicaid reimburses for behavioral health services for behavioral health professionals according to the lower of the provider's usual and customary fee or the Medicaid fee schedule. The fee schedule amounts for behavioral health procedure codes billed by physicians, psychologists and advanced practice nurses were calculated using a Resource Based Relative Value Scale (RBRVS) approach, which is described in more detail in the Physicians and Other Practitioner section.
- Medicaid pays different rates based on the practitioner. For example, physicians are paid 100 percent of the fee schedule amount for the services they provide, but psychologists and advanced practice nurses are paid 83 percent of the fee schedule amount for those same services. Licensed mental health professionals who work under the supervision of a physician are paid 75 percent of the full rate.
- CMHCs and other master's-level professionals use HCPCS Level II codes to bill for behavioral health services. Medicaid determined fees for these services through comparisons to public and private sector behavioral health rates.

CORF

- A Comprehensive Outpatient Rehabilitation Facility (CORF) provides coordinated, comprehensive outpatient rehabilitation services at one location. A CORF must provide at least physician supervision and physical therapy and social or psychological services to be certified as a CORF. CORFs may also provide the following services:
    - Drugs and biologicals which cannot be self-administered
    - Occupational therapy
    - Speech therapy
    - Orthotics and prosthetics
    - Medical supplies and equipment
    - Nursing services
- Services provided by CORFs are meant to restore the patient to safe, functional independence. Maintenance or general conditionings are not considered appropriate in the CORF setting.
- The Gottsche Center in Thermopolis is the only CORF in Wyoming. A CORF in Ft. Collins, Colorado (Center for Neurorehabilitation Services) also serves Medicaid recipients.
- Instead of a steady increase in 2010, the numbers decreased significantly and therefore sets the appearance that 2011 numbers increased dramatically. However, proportionate to 2009, CORF expenditures were right on track.
- In 2011 recipients increased significantly, although expenditures increased also they increased at a much slower pace and therefore returned a lower per recipient expenditure.
- CORF expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: CORF Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 53,680	72	$ 746
2009	59,613	83	718
2010	36,757	81	454
2011	56,646	147	385
Percent Change SFYs 2010-2011	54.1	81.5	-15.1

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid reimburses for CORF services at the lower of Medicaid's fee schedule or the provider's usual and customary charge. Effective August 1, 2008, payment for services is no longer based on the billed revenue code. Instead, to more closely resemble Medicare's payment methodology, Medicaid pays for CORF services based on a Healthcare Common Procedure Coding System (HCPCS) fee schedule.

Dental

- Medicaid covers comprehensive dental services for children and young adults under the age of 21. For recipients age 21 and older, Medicaid pays for diagnostic and preventive services, basic restorative care and removable prostheses as well as emergency tooth extraction services. Medicaid also covers orthodontic services for severe malocclusions which impact function.
- The Dental Advisory Group (DAG) advises Medicaid, the Oral Health Section, and other administrators and stakeholders about administration of the Medicaid dental program. The DAG, consisting of two specialists and three general dentists, as well as representatives from Medicaid and its fiscal agent ACS, meets quarterly. DAG members represent a wide range of interests and experience, as well as various areas of the state and various dental specialties.
- Medicaid launched the Community Oral Health Coordinator program, a county-based program that employs a dental hygienist to perform oral health screenings for children 6 months to 5 years regardless of eligibility for Medicaid. This program is described further in Section 6.

- Dental shortages exist throughout the United States. There is a shortage of dental providers in Wyoming, especially providers who treat Medicaid patients. This shortage is exacerbated by Wyoming's rural and frontier nature. Fourteen Wyoming counties are designated Dental Health Professional Shortage Areas.[76] The aging of the professional population may also affect the supply of dental services in the future, as half of Wyoming's dentists will reach retirement age by 2017.[77]
- In SFY 2011, there were 184 dental providers in the State of Wyoming, and each county had at least one dental provider except for Niobrara County.[78] These 184 dental providers provided services to 95 percent of Medicaid recipients who received dental services. Five percent of Medicaid recipients received dental services from out-of-state dental providers.
- For SFY 2011, the top five procedure codes represent 26 percent of total dental services expenditures.
- The top five providers based on expenditures accounted for $2.9 million (22 percent) of total dental expenditures.
- Although there are dental providers in most counties in Wyoming, dental specialists exist in only ten of Wyoming's 23 counties (43 percent). Thirty-seven percent of recipients of dental services received services from a specialist in SFY 2011.
- To attempt to address dental access issues, in 2007, the Wyoming Legislature passed a measure establishing an educational loan repayment program for students seeking to pursue a degree in dentistry. Dentists who establish a practice in Wyoming for a minimum number of years and accept Medicaid patients may receive repayment for a portion of their dental school tuition.
- Dental expenditures were three percent of total Medicaid expenditures for SFY 2011.

Table 1: Dental Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 10,806,229	21,695	$ 498
2009	12,062,946	23,343	517
2010	12,864,308	26,508	485
2011	13,616,853	28,293	481
Percent Change SFYs 2010-2011	5.8	6.7	-.08

[76] The Health Resource and Services Administration Health Professional Shortage areas are available by state and county at http://hpsafind.hrsa.gov.
[77] The 2010 Wyoming Oral Health Initiative Report states "Wyoming currently has 263 active dentists. Over 56% of these dentists are over the age of 51. Available on-line: http://health.wyo.gov/familyhealth/dental/index.html
[78] Providers comprise dentists and dental practices.

Table 2: Top Five Dental Procedure Codes by Expenditures – SFY 2011

Procedure Code	Procedure Code Description	Expenditures
D2930	Prefabricated Crown	$ 815,430
D0120	Periodic Oral Evaluation	705,832
D2392	Resin-Based Composite 2 Surfaces	705,626
D1120	Prophylaxis, Child	704,750
D2391	Resin-Based Composite 1 Surface	649,146
Total		**$ 3,580,784**

Table 3: Top Five Dental Procedure Codes by Units of Service – SFY 2011

Procedure Code	Procedure Code Description	Units of Service	Expenditures
D0120	Periodic Oral Evaluation	22,943	$ 705,832
D1120	Prophylaxis, Child	20,746	704,750
D1351	Sealant	13,949	378,545
D0272	Bitewing X-Ray	13,134	305,891
D1206	Topical Fluoride Varnish, Therapeutic	12,439	417,369
Total			**$ 2,512,386**

Table 4: Top Five Dental Providers by Expenditures – SFY 2011

Provider	Expenditures
Provider #1	$ 884,579
Provider #2	799,899
Provider #3	471,758
Provider #4	431,931
Provider #5	398,237
Total	**$ 2,986,405**

Table 5: Number of Dental Providers and Recipients by Wyoming County – SFY 2011

County	Number of Dental Providers	Number of Medicaid Recipients
01: Natrona	31	5,001
02: Laramie	28	7,663
03: Sheridan	12	1,263
04: Sweetwater	13	1,753
05: Albany	5	581
06: Carbon	4	375
07: Goshen	2	176
08: Platte	2	362
09: Big Horn	3	519
10: Fremont	14	2,569
11: Park	8	1,227
12: Lincoln	12	895
13: Converse	3	367
14: Niobrara	0	0
15: Hot Springs	3	279
16: Johnson	3	427
17: Campbell	7	977
18: Crook	1	58
19: Uinta	11	1,506
20: Washakie	3	930
21: Weston	3	395
22: Teton	13	838
23: Sublette	3	197
Total	**184**	**28,358**

Table 6: Dental Specialists and Recipients by Wyoming County – SFY 2011[79]

Dental Specialist	County	Number of Providers	Number of Recipients
Endodontics	01: Natrona	1	42
	02: Laramie	1	116
Orthodontics	01: Natrona	3	114
	02: Laramie	1	157
	03: Sheridan	2	32
	04: Sweetwater	1	29
	10: Fremont	1	8
	11: Park	1	151
	12: Lincoln	2	3
	19: Uinta	2	16
	22: Teton	2	27
Pedodontics	01: Natrona	2	1,580
	02: Laramie	5	5,799
	04: Sweetwater	2	755
	10: Fremont	1	331
	17: Campbell	2	345
Periodontics	01: Natrona	1	1
Surgery, Oral and Maxillofacial	01: Natrona	2	418
	02: Laramie	1	319
	22: Teton	2	170
Total		**35**	**10,413**

Highlights and Developments

- From December 2010 through December 2011, the OHS, partnering with the WyDA and Wyoming hospitals, provided 6,461 new mothers with an oral health kit upon leaving the hospital with their newborn. The kit includes an oral health education pamphlet, a "Tender Touch" to clean the infant's mouth and an infant toothbrush to use when the child starts getting primary teeth.

Reimbursement Methodology

- Medicaid reimburses for dental services at the lower of Medicaid's fee schedule or the provider's usual and customary charge. On September 1, 2004, Medicaid implemented a fee schedule for the most

[79] The dental specialties table does not include dentists or general practice providers.

commonly performed dental procedures based on the 75th percentile of the average usual and customary fee for each service at that time. There has not been an increase in fees since 2004; therefore dental procedures are no longer paid at the 75th percentile. Fees for other procedures were similarly calculated.

- Medicaid payments as a percent of billed charges were 66 percent in SFY 2010 as compared to 64 percent in SFY 2011.

DMEPOS

- Medicaid covers Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) ordered by a physician or other licensed practitioner for home use by Medicaid recipients. The purpose of providing DMEPOS is to reduce a patient's physical disability and restore the patient to his or her functional level.
- DME is defined as supplies and/or equipment that:
    - Withstand repeated use (equipment)
    - Serve a medical purpose
    - Are generally not useful to a person in the absence of illness or injury
    - Are appropriate for use in the home
    - Will not be used by any other member of the household
- Examples of DME include wheelchairs, crutches, beds and other home medical equipment.
- Supplies include diabetic supplies (not to include insulin and insulin syringes billed through the pharmacy program), syringes and needles, urinary care supplies, stocking and elastic supports, respiratory care accessories and related devices.
- Medicaid also covers most prosthetic devices, which are items that replace missing parts of the body, and most orthotic appliances, which are items employed for correction or prevention of skeletal deformities.
- DMEPOS expenditures were one percent of total Medicaid expenditures in SFY 2011.

Table 1: Total DMEPOS Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 5,476,541	6,037	$ 907
2009	6,358,280	6,716	947
2010	6,605,716	7,447	887
2011	7,505,683	7,526	997
Percent Change SFYs 2010-2011	13.6	1.1	12.4

Table 2: DME Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 4,473516	5,680	$ 788
2009	5,344,231	6,338	843
2010	5,960,375	7,097	840
2011	6,725,808	7,148	941
Percent Change SFYs 2010-2011	12.8	0.7	12.0

Table 3: POS Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,003,025	660	1,520
2009	1,014,048	691	1,468
2010	645,342	644	1,002
2011	779,875	708	1,106
Percent Change SFYs 2010-2011	20.8	9.5	10.4

Highlights and Developments

- Medicaid will continue to monitor and review DMEPOS rates.
- Medicaid contracts with a specialized utilization review contractor to perform utilization review activities including prior authorization activities and provider education. The contractor continues to work with Program Integrity on focused claim reviews every six months.

Reimbursement Methodology

- Medicaid pays for DMEPOS based on 90 percent of Medicare's fee schedule. Medicaid reviews DMEPOS rates annually. The most recent update was effective January 1, 2009, and current rates were determined after considering 90 percent of Medicare, rates paid by Medicaid in surrounding states and industry benchmarks.
- Some DMEPOS items are manually priced. Comprehensive annual review and update of DMEPOS rates occurs primarily at the beginning of each calendar year, while additional and often limited reviews and updates may occur throughout the year.
- For each covered procedure code, providers are paid the lower of usual and customary charges or the Medicaid fee schedule amount. Medicaid manually prices certain DME (for example, customized wheelchairs) according to the manufacturer's invoice price, including a 15 percent add-on, plus shipping and handling. For each new procedure code, Medicaid sets rates taking into consideration Medicare rates and other states' rates.
- Medicaid covers rental of DME, and applies rental payments toward the purchase of DME when the cost of renting equals the cost of purchase, or at the end of 10 months of rental. Medicaid automatically purchases low cost items (i.e., less than $150) and caps all rental items, except oxygen concentrators and ventilators, at the purchase price. Medicaid also caps all per-day rentals at 100 days and monthly rentals at 10 months. Medicaid does not cover routine maintenance and repairs for rental equipment.

- Medicaid pays providers for delivery of equipment to destinations outside of their normal service area (i.e., point of delivery is more than 50 miles roundtrip from the city or provider's place of business) at the State mileage rate of $0.40 per mile.
- Medicaid's DME Program activities have centered on establishing an annual standardized rate setting process that promotes transparency and consistency. DME providers are also welcome to submit requests for rate reviews as needed. Focused rate reviews examine other state Medicaid programs' fee schedules as well as industry standards to determine whether or not Medicaid rates are sufficient.

ESRD

- Medicare is the primary payer of End Stage Renal Disease (ESRD) services. Medicare ESRD coverage may begin no later than the third month after the month in which the patient begins a course of dialysis treatment. Most recipients of ESRD services are dually eligible for Medicaid and Medicare services. During the 90-day Medicare eligibility determination period, Medicaid will reimburse ESRD services for eligible individuals and will reimburse for services if Medicare denies eligibility.
- Medicaid covers all medically necessary services related to renal disease care, including inpatient renal dialysis, and outpatient services related to ESRD treatment. The client must be eligible for Medicaid, and the hospital or free-standing facility must be certified as an ESRD facility.
- Medicaid will also pay for treatment if Medicare denies coverage for an eligible individual on a home dialysis program. Medicaid does not cover personal care attendants for this program.
- Although most ESRD recipients are dual eligible individuals, most Medicaid expenditures are for non-dual recipients because Medicare pays for the majority of the ESRD services for dually eligible individuals.
- The 28% decrease in expenditures for SFY 2011 is due to a decrease in Medicaid rates from 70% of billed charges to 24% of billed charges.
- Expenditures for ESRD services were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: ESRD Services for Non-Dually Eligible Individuals: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,212,163	69	$ 17,568
2009	1,347,305	72	18,713
2010	1,160,798	83	13,986
2011	835,621	86	9,717
Percent Change SFYs 2010-2011	-28.0	3.6	-30.5

Highlights and Developments

- Effective September 1, 2010, Medicaid revised its SFY 2011 ESRD payment methodology to reimburse ESRD services at 24 percent of billed charges (excluding lab services which are to be paid using the lab fee schedule), which results in a payment rate that is comparable to what Medicare would pay for the service.
- The State also has a program to pay for ESRD services using only state funds. This State-only funded program originally paid commercial rates for dialysis services, but now reimburses at Medicare rates, which are substantially lower than commercial rates.

Reimbursement Methodology

- In SFY 2011, reimbursement was altered to follow the state plan amendment which requires that Free-standing ESRD clinics will be reimbursed at the lesser of the Medicare rate for services in the state where the facility is located or billed charges. Due to Medicare changes in reimbursement, Medicaid rates decreased from 70% of billed charges to 24% of billed charges.
- Medicaid will be altering reimbursement amounts to remain consistent with its State Plan. Medicare is doing a phased in approach to a prospective payment system beginning in 2011 and completing in 2014. Wyoming Medicaid will follow this phased in approach using a percentage of billed charges for reimbursement changes.

FQHC

- Federally Qualified Health Centers (FQHC) provides preventive primary health services. Medicaid reimburses services provided at a FQHC if they are medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse mid-wife, visiting nurse, licensed clinical psychologist or licensed clinical social worker.
- Medicare designates a facility as an FQHC if it is located in an area designated as a "shortage area." Shortage areas are defined geographic areas designated by the Department of Health and Human Services as having either a shortage of personal health services or a shortage of primary medical care manpower. FQHCs differ from RHCs based on several criteria related to location, shortage area, corporate structure, requirements for a board of director and clinical staffing requirements.[80]
- Expenditures increased in SFY 2011, coinciding with an increase in recipients. However, because the increase in recipients increased at a faster rate than the increase in expenditures, the expenditures per recipient decreased.
- Expenditures for FQHC services were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: FQHC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 3,058,897	3,793	$ 806
2009	4,113,634	4,532	908
2010	2,864,956	4,110	697
2011	3,103,164	4,855	639
Percent Change SFYs 2010-2011	8.3	18.1	-8.3

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

[80] Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, US Department of Health and Human Services Health Resources and Services Administration, Revised June 2006. Available on-line: http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf

Reimbursement Methodology

- Medicaid reimburses FQHCs according to a prospective payment system (PPS) as required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The PPS is based on 100 percent of a facility's average costs per encounter during SFY 1999 and SFY 2000. FQHCs are paid the prospective rate, without a comparison of actual charges to the fee schedule amount. The rates are updated annually for inflation based on the Medicare Economic Index (MEI). The most recent increase was 0.4 percent effective January 1, 2011. In addition, adjustments may be made to rates if a provider requests a review of its rate based on a change to its scope of service. The per-encounter rate includes the office visit, as well as any ancillary services provided (x-rays, etc.).

Home Health

- Medicaid covers home health services if the Medicaid recipient is not an inpatient of a hospital or nursing care facility. Covered services must be:
    - Intermittent
    - Three or fewer visits a day for home health aide and/or skilled nursing services, where each visit does not last more than four hours
    - Medically necessary and ordered by a physician
    - Documented in a signed and dated Plan of Treatment that is reviewed and revised as medically necessary by the attending physician, at least once every 60 days
- Covered services include:
    - Skilled nursing services
    - Home health aide services supervised by a qualified professional
    - Physical therapy services provided by a qualified, licensed physical therapist
    - Speech therapy provided by a qualified therapist
    - Occupational therapy provided by a qualified, registered or certified therapist
    - Medical social services provided by a qualified, licensed MSW or BSW-prepared person supervised by an MSW
- Medicaid does not cover homemaker services, respite care, meals on wheels or services that are inappropriate or not cost-effective when provided in the home setting.
- Home Health agencies must provide at least two of the covered services in order to be a licensed provider in the state of Wyoming.
- Home health expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Home Health Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,719,307	529	$ 3,250
2009	1,998,695	552	3,621
2010	1,941,097	587	3,307
2011	2,732,905	623	4,387
Percent Change SFYs 2010-2011	40.8	6.1	32.7

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid reimburses home health providers on a per visit basis. Effective July 1, 2006, home health providers received a Medicaid rate increase of 30 percent from $64 per visit to $84 per visit for skilled nursing, physical therapy, speech therapy, occupational therapy, home health and medical social worker services. This was the first rate increase since 1989, when the rates were originally set.

Hospice

- Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual and physical needs of dying patients. Medicaid reimburses hospice care for Medicaid recipients if a physician certifies that the recipient is terminally ill and the recipient elects to receive hospice care.
- Medicaid reimburses hospice, independent physician services and HCBS services provided to the recipient in a hospice setting. Covered services include routine and continuous home care, inpatient respite care and general inpatient care. Inpatient services are provided during critical periods for patients who need a high level of care.
- Hospice expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Hospice Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 608,579	86	$ 7,077
2009	939,603	115	8,170
2010	1,432,471	147	9,745
2011	1,036,887	150	6,913
Percent Change SFYs 2010-2011	-27.6	2.0	-29.1

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid reimburses hospice providers based on Medicare rates, which CMS and the State implement every October. The most recent update was in October 2011.
- Most hospice services are provided at home. In situations where a nursing facility resident elects to receive hospice care, the resident may receive hospice benefits if the hospice and the nursing facility have a written agreement that the hospice will take responsibility for management of the individual's hospice care, and the nursing facility will provide room and board. In these instances, Medicaid will pay the hospice 95 percent of the room and board portion of the nursing facility's per-diem rate, and the hospice will reimburse the nursing facility according to its agreement.
- Likewise, for inpatient respite care and general inpatient care, the recipient may receive inpatient hospice services if the hospice provider and the hospital have a written agreement. Medicaid reimburses the hospice provider; the hospice provider reimburses the hospital according to their agreement.

Hospital

- Medicaid covers both inpatient and outpatient hospital services. Additional information on covered inpatient and outpatient services is in the sections that follow.
- The increase in expenditures represents a proportional increase to total Medicaid expenditures.
- Hospital expenditures were 22 percent of total Medicaid expenditures in SFY 2011.

Table 1: Total Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures[81] (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)	QRA Payments (Federal Share) (D)	Total Expenditures with QRA Payments (E)=(A+D)
2008	$ 94,331,252	38,892	$ 2,425	$ 5,329,778	$ 99,661,030
2009	102,377,478	42,724	2,396	6,634,910	109,012,388
2010	113,641,274	43,704	2,600	8,797,381	122,438,655
2011	114,357,604	43,940	2,603	6,828,879	121,186,483
Percent Change SFYs 2010-2011	0.6	0.5	0.1		-1.0

Highlights and Developments

- Medicaid has a Hospital Advisory Group (HAG), which meets quarterly. The HAG includes the Wyoming Hospital Association and six executives from hospitals throughout Wyoming. HAG discussions focus on new and upcoming issues within the healthcare industry, member concerns and presentations from any outside source that has information relevant to the hospital industry.

Reimbursement Methodology

- Medicaid reimburses inpatient and outpatient hospital services using different reimbursement methodologies. The following sections describe the methodology for each in further detail.
- Medicaid annually reviews data regarding its payment methodologies, including information about cost coverage by type and location of provider and types of services provided.

Inpatient Hospital

- Medicaid covers inpatient hospital services, with the following exceptions: alcohol and chemical rehabilitation services, cosmetic surgery and experimental services. In addition, Medicaid covers only those surgical procedures that are medically necessary. Medicaid may not cover a surgery if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the patient.
- Medicaid annually reviews data regarding its inpatient payment methodology, including information about cost coverage by type and location of provider and types of services provided. In SFY 2009, the State noted that cost coverage for out-of-state hospitals was considerably higher than cost coverage for in-state hospitals. To address these issues in addition to others (e.g., update capital payments, review

[81] Total hospital expenditures include adjustments that could be either inpatient or outpatient.

graduate medical education payments, update the level of care payment classifications), Medicaid rebased its level of care system in SFY 2010.

- Inpatient hospital expenditures were 16 percent of total Medicaid expenditures in SFY 2011.

Table 1: Inpatient Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)	QRA Payments (Federal Share) (D)	Total Expenditures with QRA Payments (E)=(A+D)
2008	$ 73,959,742	12,187	$ 6,069	$ 2,897,680	$ 76,857,422
2009	79,509,583	12,041	6,603	3,369,460	82,879,043
2010	87,297,343	12,288	7,104	4,047,431	91,344,774
2011	84,557,214	11,745	7,199	2,379,785	86,936,999
Percent Change SFYs 2010-2011	-3.1	-4.4	1.3		-4.8

Highlights and Developments

- Effective September 1, 2009, the Wyoming Legislature approved a budget reduction over two years for inpatient hospital services. The rebased LOC system takes this reduction into account.
- Beginning September 1, 2009, Medicaid implemented a quarterly payment adjustment process that reviews inpatient hospital claims from the prior state fiscal quarter for certain hospital acquired conditions and Medicare National Coverage Determinations related to "healthcare acquired conditions" or other provider preventable conditions.[82] Medicaid reviews discharges and uses CMS guidelines to reduce payments when specified conditions are acquired during hospitalization (i.e., the condition was not present on admission) and would have resulted in additional payment. This policy reflects similar payment reductions implemented and used by CMS.
- Effective July 1, 2010, the Wyoming Legislature mandated a rate freeze for inpatient hospital services amounting to a budget reduction of $1.9 million.

Reimbursement Methodology

- Medicaid pays for inpatient hospital services using three different approaches, depending upon the type of service:
    - Level of care prospective rate per discharge – Used to pay for general inpatient acute care services

[82] According to CMS, "healthcare acquired conditions" are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

  - Prospective per diem rate – Used to pay for rehabilitation services provided with a ventilator and a separate per diem rate to pay for services provided without a ventilator
  - Payment of 55 percent of billed charges – Used to pay for transplant services
  - Letters of agreement – Used for specialty services not otherwise obtainable in Wyoming.
- Medicaid made modifications to the inpatient hospital payment methodology in SFY 2010 (effective September 1, 2009).

Level of Care (LOC) Methodology

- In the LOC system, Medicaid pays a prospective payment amount per discharge. Each discharge is classified into a LOC based on diagnosis codes, procedures or revenue codes that hospitals report on the inpatient claim.
- For the purposes of LOC payment, participating hospitals are all in-state hospitals that are enrolled as Medicaid providers as well as out-of state hospitals enrolled as Medicaid providers that received a specified level of Medicaid payments.
- In SFY 2010, Medicaid rebased the inpatient level of care system using more recent cost and claims data to better categorize services and to calculate new payment rates. The LOCs in the rebased system are:
  - Rehabilitation with ventilator
  - Rehabilitation
  - Maternity (medical)
  - Maternity (surgical)
  - Neonatal intensive care unit
  - Intensive care, critical care and burn units
  - Surgery
  - Psychiatric care
  - Newborn nursery
  - Routine care

Disproportionate Share Hospital (DSH) Payments

- Medicaid makes additional payments to hospitals that serve a disproportionate number of low-income patients. These DSH payments are required by federal law and are capped according to state-specific allotments.[83]
- Beginning with the FFY 2009 DSH payments, Medicaid determined the amount of DSH payment to each qualifying hospital based on its unreimbursed Medicaid costs, i.e., the Medicaid payment deficit. Medicaid calculated the payment deficit, or the difference between Medicaid payments and Medicaid costs as reported on the cost report, and distributed DSH payments based on each hospital's Medicaid payment deficit as a percentage of all hospitals' Medicaid payment deficits, not to exceed the above mentioned federal allotment.
- For FFYs 2009 and 2010, the ARRA provided for a 2.5 percent increase in the State's DSH allotment. In FFY 2010, Wyoming's federal DSH allotment after ARRA was $233,831 ($467,662 including State

[83] Section 1923 of the Social Security Act, codified at 42 U.S.C. § 1396r-4

Medicaid share).[84] Wyoming's DSH allotment increases annually at the rate of increase in the Consumer Price Index.

- As part of the Affordable Care Act, DSH allotments are expected to start decreasing beginning in 2014. This section of the Affordable Care Act will not affect the mechanism the state uses to distribute or pay the DSH dollars; it will only alter the amount allocated.

Qualified Rate Adjustment (QRA) Payments

- Medicaid also supplements qualified inpatient hospital providers with QRA payments. Medicaid paid 20 hospitals a total $4.8 million in inpatient hospital QRA payments during SFY 2011 (federal and state share).[85] Qualifying hospitals, i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs, provide the state share of the QRA payment, and the State then distributes the corresponding federal matching Medicaid funds as well as the state share to the participating hospitals.

Outpatient Hospital

- Outpatient hospital departments provide outpatient hospital services including emergency room, surgery, laboratory, radiology and other testing services. Medicaid limits visits to hospital outpatient departments, physician offices and optometrist offices to a maximum of 12 per calendar year for recipients over the age of 21. Limits do not apply to recipients under age 21 or Medicare crossovers. Family planning visits, Health Check services and emergency services for all recipients are exempt from the 12-visit limit.[86]
- Outpatient hospital expenditures were six percent of total Medicaid expenditures in SFY 2011.

[84] To access the increased portion of their Federal Medicaid DSH allotments as authorized under ARRA, Wyoming had to exhaust its original FY 2009 Federal Medicaid DSH allotments (un-adjusted by ARRA). Health and Human Services, "Disproportionate Share Hospital" available online: http://www.hhs.gov/recovery/cms/dsh.html. The DSH payments reported are payments calculated using FFY 2010 paid claims data and made during SFY 2011.
[85] The inpatient QRA payments reported are payments calculated using SFY 2010 paid claims data and made during SFY 2011.
[86] The Health Check program is formerly known as EPSDT.

Table 1: Outpatient Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)	QRA Payments (Federal Share) (D)	Total Expenditures with QRA Payments (E)=(A+D)
2008	$ 20,086,241	35,954	$ 559	$ 2,432,098	$ 22,518,339
2009	22,966,428	40,159	572	3,265,450	26,231,878
2010	26,267,488	40,847	643	4,749,950	31,017,438
2011	29,691,724	41,348	718	4,449,094	34,140,818
Percent Change SFYs 2010-2011	13.0	1.2	11.7		10.1

Table 2: Services Excluded from APC Methodology and Paid by Fee Schedule

Service	Fee Schedule
Selected DME	DME fee schedule
Selected vaccines and immunizations, selected radiology and mammography screening and diagnostic mammographies and Therapies	Physician fee schedule
Laboratory services	Laboratory fee schedule
Corneal tissue, dental and bone marrow transplant services; and new medical devices covered under Medicare's transitional pass-through payments	Percent of charges

Highlights and Developments

- Medicaid annually reviews data regarding its outpatient payment methodology, including estimates of cost coverage.

Reimbursement Methodology

- Medicaid implemented an Ambulatory Payment Classification (APC)-based bundled outpatient hospital payment system on October 1, 2005 for all hospitals. The APC system groups services for payment the same way as Medicare does and uses many of Medicare's APC payment policies, adjusted to reflect the Medicaid population. Medicaid pays for the following services under APCs:

- Significant outpatient procedures[87]
- Ancillary services
- Drugs
- Selected laboratory services
- Radiology
- Selected durable medical equipment, prosthetics and orthotics
- Selected vaccines and immunization services that are not paid for under Medicaid's physician fee schedule

- The goals of Medicaid's APC-based system are to promote equity and consistency of outpatient hospital payments among provider types, predictability of outpatient hospital payments and access to quality care. Specific objectives of the project are aligned with Medicaid's overall strategic direction to improve the efficiency and effectiveness of operations relating to the provision of customer services such as healthcare to Medicaid recipients.

APC-Based Methodology

- The APC methodology is designed to pay hospitals based on the resources used to provide a service. For each unit of service, payment equals the scaled relative weight for the APC, multiplied by a conversion factor.[88] When multiple units of services and different services are provided, payments are subject to discounting and unit limitations.
- Medicaid uses three conversion factors that vary by hospital type: children's, general acute and critical access hospitals.
- Medicaid excludes select services from the APC methodology and pays for them using a separate Medicaid fee schedule.
- Medicaid processes all outpatient claims through the Integrated Outpatient Code Editor (I/OCE). The I/OCE was developed and is updated quarterly by CMS. Medicaid also updates the I/OCE every quarter. Although both Medicare and Medicaid update the I/OCE every quarter, Medicaid is a quarter behind the I/OCE version Medicare uses.
- In addition to the I/OCE quarterly updates, Medicaid annually updates the relative weights and the conversion factors.
- In SFY 2010 due to Wyoming Legislative rate freezes the conversion factors were held stagnant. In SFY 2011, the conversion factors were updated to keep payments consistent with changing relative weights but were kept budget neutral between the three categories of hospitals.

Qualified Rate Adjustment Payments

- Medicaid also supplements qualified outpatient hospital providers with QRA payments as described in the Inpatient Hospital section. Medicaid paid 20 hospitals a total of $8.9 million in outpatient hospital QRA payments in SFY 2011 (federal and state share).[89] Qualifying hospitals provide the state share of the QRA payment, and the State then distributes the corresponding federal matching Medicaid funds as well as the state share to the participating hospitals.

[87] A procedure provided to a Medicaid enrollee that constitutes the primary reason for the visit to the healthcare professional.
[88] The scaled relative weight for an APC measures the resource requirements of the service and is based on the median cost (Medicare) of services in that APC. The conversion factor translates the scaled relative weights into dollar payment rates.
[89] The outpatient QRA payments reported are payments calculated using SFY 2010 paid claims data and made during SFY 2011.

Interpreter

- Medicaid covers interpreter services for individuals who have Limited English Proficiency (LEP) or are deaf or hard of hearing. Hard of hearing is defined as "limited hearing which prevents an individual from hearing well enough to interact effectively with healthcare providers." The purpose of providing these services is to assist the patient in communicating effectively about health and medical issues. Medicaid offers interpretation services in over 90 languages.
- Medicaid does not cover interpreter services in conjunction with the following services:
    - Inpatient or Outpatient hospital services
    - ICF-MR
    - Nursing facilities
    - Ambulance services by public providers
    - PRTFs
    - Comprehensive inpatient or outpatient rehabilitation facilities
    - Other agencies/organizations receiving direct federal funding
    - Interpreter services provided by family members or by a volunteer, associate or friend
    - Interpreter services provided for the same recipient on the same day more than once if provided in conjunction with Medicaid healthcare services delivered by different providers.
- Medicaid began covering interpreter services in 2006 and has three enrolled providers who specialize in interpretation services. Unfortunately, interpreter services are underutilized and reasons for this are unclear. Medicaid continues to review and analyze Interpreter Services to identify the underlying cause(s) for underutilization of services as well as to determine whether or not the current reimbursement rate is sufficient to meet provider and recipient needs.
- Interpreter service expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Interpreter Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 54,293	427	$ 127
2009	49,399	407	121
2010	47,837	384	125
2011	54,259	420	129
Percent Change SFYs 2010-2011	13.4	9.4	3.7

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges. Interpretation providers are reimbursed for time spent with the recipient.

Laboratory

- Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and treatment of the patient as specified in the treatment plan developed by the ordering practitioner.
- Laboratory expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Laboratory Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 870,306	9,216	$ 94
2009	852,797	9,278	92
2010	1,121,964	9,855	114
2011	1,171,185	9,956	118
Percent Change SFYs 2010-2011	4.4	1.0	3.3

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.
-

Reimbursement Methodology

- Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for laboratory services.

Nursing Facilities

- Medicaid covers nursing facility services for individuals who are no longer able to live in the community. Wyoming also provides long-term care services through a Long Term Care (LTC) Waiver and an Assisted Living Facility (ALF) Waiver, and to individuals with developmental disabilities through separate waivers. This section focuses on nursing facility services. The LTC and ALF Waivers and long-term care for individuals with developmental disabilities are discussed in the Waiver sections.
- A nursing facility is an institution (or a distinct part of an institution), which is not primarily for the care and treatment of mental diseases, and provides:[90]
    - Skilled nursing care and related services for residents who require medical or nursing care
    - Rehabilitation services for the rehabilitation of injured, disabled or sick persons
    - Health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities
- Expenditures and recipient decreased in SFY 2011; however, because recipients decreased at a higher rate than expenditures decreased, an increase in expenditures per recipient occurred.
- Nursing facility expenditures were 14 percent of total Medicaid expenditures in SFY 2011.

Table 1: Nursing Facilities Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)	Provider Assessment (Federal Share) (D)	Total Expenditures with Provider Assessment (E) = (A+D)
2008	$ 69,274,191	2,450	$ 28,275	0	$ 69,274,191
2009	73,188,663	2,478	29,535	0	73,188,663
2010	75,434,811	2,611	28,891	0	75,434,811
2011	73,180,333	2,460	29,748	2,899,414	76,079,747
Percent Change SFYs 2010-2011	-3.0	-5.8	3.0		0.9

[90] The Wyoming Medicaid Rules cite the definition of Nursing Facility in 42 USC § 1396r, Requirements for Nursing Facilities.

Highlights and Developments

- Medicaid has a Nursing Home Advisory Group (NAG), which meet quarterly. Members include State staff, nursing facility administrators and directors of nursing. The group discusses issues important to nursing facilities and works to develop solutions to issues.
- There appears to be a particular need for staff trained to care for geriatric psychiatric residents. Currently, Medicaid transfers residents with high-level psychiatric needs to out-of-state facilities.
- Effective April 1, 2011 the Provider Assessment for Nursing Facilities was approved by CMS through a State Plan Amendment after Wyoming Legislative approval.

Reimbursement Methodology

- Medicaid reimburses a per diem rate for nursing facilities. This rate covers routine services and limited reserve bed days. Routine services include room, dietary, laundry, nursing, minor medical surgical supplies, non-legend pharmaceutical items (including over-the-counter drugs and products, insulin and diabetic supplies) and the use of equipment and facilities. Medicaid may reimburse for reserve bed days during a resident's temporary absence, based on nursing facility occupancy levels.
- Medicaid calculates facility per diem rates each fiscal year using facility-specific cost data based on each provider's fiscal year end. A facility's per diem rate may not exceed the maximum rate established by Medicaid. The current median per diem rate is $165.56.
- Medicaid rates for nursing facilities have been held to the 2009 rate, per a Wyoming Legislative budget footnote that required a rate freeze.
- Medicaid reimburses separately, outside of the facility's per diem, for physician visits, hospitalizations, laboratory, x-rays and for prescription drugs for residents of a nursing facility.
- Medicaid provides additional reimbursement outside of the per diem rate on a monthly basis for services provided to a recipient with extraordinary needs. Medicaid determines per case rates for extraordinary recipients based on relevant cost and a review of medical records.

Physicians and Other Practitioners

- Medicaid uses the RBRVS Medicaid physician fee schedule to pay for medical services provided by several categories of practitioners, including physicians, physician assistants, physical and occupational therapists, ophthalmologists and nurse practitioners.
- Medicaid limits visits to hospital outpatient departments, physician offices and optometrist offices to a maximum of 12 per calendar year for recipients over the age of 21. Limits do not apply to recipients under age 21 or Medicare crossovers. Family planning visits, Health Check services and emergency services for all recipients are exempt from the 12-visit limit.[91]
- General practice physicians' expenditures make up 26 percent of the total physician and practitioner expenditures. The expenditures for general practice physicians were over four times that of surgery providers.
- The physician expenditures reported in this section exclude services billed by psychiatrists and routine vision services performed by ophthalmologists. Discussions of expenditures for these two service areas are found in the Behavioral Health and Vision sections.

[91] The Health Check program is formerly known as EPSDT.

- Physician and other practitioners' expenditures were 13 percent of total Medicaid expenditures in SFY 2011.

Table 1: Physician and Other Practitioner Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 58,085,167	58,054	$ 1,001
2009	61,701,932	60,248	1,024
2010	65,301,194	63,626	1,026
2011	65,168,221	65,060	1,002
Percent Change SFYs 2010-2011	-0.2	2.3	-2.4

Table 2: Physician Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 54,890,853	57,602	$ 953
2009	58,455,444	59,817	977
2010	60,897,482	63,136	965
2011	59,821,711	64,427	929
Percent Change SFYs 2010-2011	-1.8	2.0	-3.7

Table 3: Other Practitioner Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 3,194,314	5,922	$ 539
2009	3,246,489	6,427	505
2010	4,403,713	7,178	614
2011	5,346,509	8,339	641
Percent Change SFYs 2010-2011	21.4	16.2	4.5

Table 4: Physician and Other Practitioners SFY 2011 Expenditures by Provider Taxonomy, Arrayed by Expenditures

Provider Type	Number of Providers	Expenditures ($)
General Practice	187	$ 16,669,656
OB/GYN	63	11,542,105
Pediatrics	79	8,233,178
Internal Medicine	137	6,411,265
Surgery	136	3,952,878
Emergency Medicine	26	3,800,063
Physical Therapist	54	2,776,082
Anesthesiology	82	2,688,531
Diagnostic Radiology	57	2,557,894
Otolaryngology	31	1,097,720
Urology	20	887,064
Psychiatry and Neurology: Neurology	23	781,629
Ophthalmology	36	641,548
Occupational Therapist	13	519,915
Nurse Anesthetist, Certified Registered	23	491,532
Allergy and Immunology, Allergy	6	457,860
Pathology	20	414,608
Family Health	10	308,796
Dermatology	16	306,992
Speech-Language Pathologist	8	227,230
Physical Medicine and Rehabilitation	12	135,880
Nurse Practitioner	6	118,770
Podiatrist	18	76,857
Audiologist	15	53,035
Midwife, Certified Nurse	6	16,281
Neuromusculoskeletal Medicine	1	853
Total	**1,085**	**65,168,221**

Highlights and Developments

- Medicaid has a Physician Advisory Group (PAG), which meets quarterly. Members include State staff, physicians, and medical practitioners. The group discusses issues important to physicians and medical practitioners and works to develop solutions to issues.
- Due to constraints on the Medicaid budget, effective July 1, 2010, Medicaid discontinued the annual update of fees.
- Implementing a standard annual rate of increase for physicians and other practitioners paid by the Medicaid physician fee schedule would allow for predictable payment levels over time. Linking Wyoming's conversion factors and relative weights to Medicare rates may also support this process.

Reimbursement Methodology

- Medicaid pays the lower of the provider's usual and customary charges or the RBRVS fee schedule for physician and other practitioners' services, excluding some select providers and services.
- The RBRVS is based on the estimates of the costs of resources required to provide physician services and includes a relative value unit (RVU) and a conversion factor. Each RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, considering the time and intensity of the physician's effort in providing a service, the physician's practice expense and malpractice expenses. Then, the RBRVS RVU for a particular procedure are multiplied by a conversion factor (the average cost for all procedures) to determine the actual dollar amount for the fee schedule.
- Anesthesiologists are paid through a different fee schedule. The fee schedule for anesthesiologists is based on RVUs developed and published by the American Society of Anesthesiologists.
- Medicaid and the Wyoming Legislature have made several updates over time to the physician reimbursement methodology. In SFY 2007, Medicaid adopted Medicare RVUs from calendar year 2006 and adjusted the payment rates for physician services. A Wyoming legislatively mandated increase in funding of approximately $1,490,000 for physician services, which includes approximately $280,000 for selected anesthesia services, provided for the conversion factor increase.

Prescription Drugs

- Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most recipients. Exceptions may apply for specific products or conditions, such as pregnancy.
- Data includes expenditures for pharmacies only and does not take into account rebate amounts.
- Prescription drug OBRA rebate amounts for each SFY were:
    - $12.7 million in SFY 2006
    - $8.4 million in SFY 2007
    - $9.4 million in SFY 2008
    - $12.5 million in SFY 2009
    - $13.6 million in SFY 2010
    - $17.8 million in SFY 2011
- Expenditures were eight percent of total Medicaid expenditures in SFY 2011.

Table 1: Prescription Drugs Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	35,059,070	44,784	783
2009	39,302,672	45,466	864
2010	38,750,658	49,043	790
2011	41,330,767	50,131	824
Percent Change SFYs 2010-2011	6.7	2.2	4.3

Table 2: Pharmacy Cost Avoidance — SFY 2011[92]

Program Area	Cost Avoidance[93]
Prior Authorization/Preferred Drug List	$ 5,115,660
SMAC	4,417,554
Total Cost Avoidance	**$ 9,533,214**

Highlights and Developments

- In SFY 2011, the Medicaid Pharmacy Program designated preferred drugs in 80 specific drug classes. The Pharmacy & Therapeutics (P&T) Committee regularly reviews additional therapeutic classes for preferred status.
- The Prior Authorization Decision Support System (PADSS) allows Medicaid to more efficiently automate and evaluate prior authorization requests.
- The Medicaid Pharmacy Program is continually updating claims processing system edits to improve claims processing efficiency, to improve and promote appropriate clinical utilization of medication and to identify ways to reduce pharmacy claims costs. Some examples of edits include quantity limits, early refills, age limits and mandatory generics. Ongoing system edits have helped to generate savings to Medicaid's prescription drug programs.
- Wyoming also has a Drug Utilization Review (DUR) program to ensure Medicaid recipients are receiving appropriate, medically necessary medications, as discussed in more detail in Section 6.
- The Federal Drug Rebate Program requires pharmaceutical manufacturers to pay rebates if they want to have their drugs covered by Medicaid. This federal mandate provides state Medicaid programs the opportunity to receive greatly discounted prices on medications similar to those offered by

[92] Total Cost Avoidance dollars come from both Medicaid and the Prescription Drug Assistance Program (PDAP). PDAP contributes a lesser amount of the total dollars and is funded 100 percent using State General Funds.
[93] Net of administrative costs.

pharmaceutical manufacturers to large purchasers in the marketplace. The Medicaid pharmacy program collected $17.8 million in OBRA rebates for SFY 2011.

- The Medicaid Pharmacy Program is a member of the Sovereign States Drug Consortium (SSDC) which is a pharmaceutical purchasing pool group. It is a syndicate of states working together to negotiate supplemental rebates from pharmaceutical manufacturers for prescription drugs included on states' preferred drug lists. Supplemental rebates enhance the saving states realize in addition to federal (OBRA) rebates. Goold Health Systems was selected to mange the program for the SSDC. With the continued expansion of Wyoming's Preferred Drug List, the Medicaid Pharmacy Program has collected a total of $1,373,012 in supplemental rebate payments in SFY 2011.
- On July 8, 2011 CMS announced that Myers and Stauffer, LC had been awarded a contract for the "Survey of Retail Prices: Payment and Utilization Rates, and Performance Rankings." The purpose of the Survey of Retail Prices is to develop a monthly survey of retail community pharmacy prescription drug prices and the generation of publicly available pricing files. It is anticipated these files will afford State Medicaid agencies with a valid array of covered outpatient drug information, regarding retail prices for the ingredient costs of prescription drugs and consumer purchase prices for such drugs. State Medicaid agencies will be able to use this information to compare their own pricing methodologies and payments to those derived from this survey. Additionally, on an annual basis, CMS will obtain from the State Medicaid agencies information on their prescription drug payment and utilization rates and prepare a comparative report regarding the performance of the States' reimbursement prices and the national retail price data collected in the survey. The survey is anticipated to be released sometime in 2012.

Reimbursement Methodology

- Medicaid pays for prescription drugs at the lower of the estimated acquisition cost of the ingredients, the Federal Upper Limit (FUL), the State Maximum Allowable Cost (SMAC) plus the dispensing fee, or the provider's usual and customary charge. The estimated acquisition cost is 89 percent of the average wholesale price (AWP) for the ingredients (more commonly known as the average wholesale price minus 11 percent). The dispensing fee for pharmacy claims is $5.00 per claim.
- SMAC rates are designed to maximize cost-effectiveness of pharmacy services by setting reimbursement amounts for therapeutically equivalent drug products at the same price, based on the cost of the products[94]. SMAC rates on multisource drugs and some brand name drugs are updated on a monthly basis and as needed. Use of the SMAC pricing list contributes substantially ($4.4 million) to the overall pharmacy cost avoidance for the Medicaid Pharmacy Program. The Department conducts an annual pricing survey to determine actual acquisition costs specific to Wyoming pharmacies.
- Medicaid recipients pay co-payments for prescription drugs as follows: $1.00 for generics and $3.00 for all brand-name medications. Nursing facility residents, pregnant women, children younger than 21 years of age, family planning services, emergency services and hospice services are exempt from co-payments.

[94] State of Wyoming Pharmacy homepage Available online: http://wyMedicaid.org/smac%20for%20detailed%20information

PRTF

- Medicaid covers psychiatric residential treatment for individuals under age 21 in a Psychiatric Residential Treatment Facility (PRTF).
- A PRTF is a standalone entity providing a range of comprehensive services to treat the psychiatric conditions of residents on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. PRTFs are nationally accredited through the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation of Services for Families and Children (COA).
- Each resident has an Individualized Plan of Care developed by a team of physicians and mental health specialists employed by or providing services at the PRTF. The Plan of Care confirms the need for residential psychiatric care and is designed to achieve the recipient's discharge from the inpatient status at the earliest possible time. The team of specialists' reviews this plan at least every 7 days (will vary by recipient and their level of need) and documents responses to treatment and any revised plans. This plan assists in determining the medical necessity of a continued stay, or documenting progress towards goals to assist with discharge planning.
- The PRTF is responsible for any medical services that an individual might need while in the custody of the PRTF, for example, the PRTF must pay for dental care, vision and pharmacy services associated with physical health services. Medicaid may choose to include a provider-specific medical add-on to its per diem rate to pay for these additional services.
- The decrease in expenditures for PRTF-RTF for SFY 2011 is due to 12 less PRTF-RTFs available to provide services for recipients and the criteria for PRTF admissions and continue stay reviews was rewritten and updated. This criteria is more stringent in that local resources must be explored before an admission out of state to an inpatient psychiatric facility is approved.
- PRTF expenditures were three percent of total Medicaid expenditures in SFY 2011.

Table 1: PRTF Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 8,387,267	258	$ 32,509
2009	8,345,259	237	35,212
2010	14,658,731	438	33,467
2011	15,244,613	404	37,734
Percent Change SFYs 2010-2011	4.0	-7.8	12.7

Table 2: PRTF-RTF Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 15,547,407	365	$ 42,596
2009	18,828,243	392	48,031
2010	8,335,609	285	29,248
2011	197,009	14	14,072
Percent Change SFYs 2010-2011	-97.6	-95.1	-51.9

Highlights and Developments

- Medicaid continues to contract with Navigant Consulting to collect and analyze provider Medicaid cost reports. Navigant Consulting collected 2010 Medicaid cost reports from providers and in the fourth quarter of SFY 2011 performed an analysis to develop rate recommendations for SFY 2013-2014. These rate recommendations are currently being reviewed and will be determined at a later date.
- Effective November 1, 2009, Medicaid dis-enrolled all Residential Treatment Facilities (RTF) per CMS guidelines.
- Medicaid will continue to work with its enrolled PRTFs, CMS, and other State agencies and stakeholders to ensure compliance with federal guidelines, and make appropriate changes.
- Total amount spent (State General Funds only/no FFP) for PRTF clients court ordered to a specific facility – September 2010- June 2011- $2,340,577.71- 89 unique clients. These services are not eligible for federal Medicaid matching funds.

Reimbursement Methodology

- Medicaid reimburses for PRTF services using an all-inclusive, per diem rate developed using costs reported on provider Medicaid cost reports. The per diem rate includes room and board, treatment services specified in the treatment plan, and may include an add-on amount for medical services.

Radiology

- Medicaid covers radiology services including x-ray, screening mammography, ultrasound, radiation therapy and nuclear medicine services, if ordered by a physician or a nurse practitioner. This section discusses two types of expenditures related to radiology: mobile radiology and the professional component of radiology billings for services provided by a physician or other practitioner. Mobile radiology expenditures are unique to this section of this Report, while the expenditures for the professional component of physician radiology that are presented here are also presented elsewhere in this Report.

- Mobile radiology expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Mobile Radiology Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 238,086	502	$ 474
2009	191,239	485	394
2010	222,281	505	440
2011	217,463	557	390
Percent Change SFYs 2010-2011	-2.2	10.3	-11.3

Table 2: Physician Radiology Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 4,617,336	24,625	$ 188
2009	4,650,857	25,335	184
2010	4,958,377	26,673	186
2011	5,304,938	26,750	198
Percent Change SFYs 2010-2011	7.0	0.3	6.7

Highlights and Developments

- Medicaid reviewed the fee schedule in January 2011 and maintained Medicaid rates below Medicare reimbursement levels.

Reimbursement Methodology

- Payments for radiology services are made for both professional services (e.g., the radiologist or the radiation oncologist) and facility services (e.g., the hospital). These payments are calculated based on the RBRVS fee schedule; for more information about this methodology, see the Physicians and Other Practitioners section.
- The professional services component of the rate is based on a RVU that comprises physician work, practice expense and malpractice cost. The technical component of the rate is based on an RVU that comprises facility practice expense and facility malpractice. Both components are then multiplied by a conversion factor to calculate the dollar value of the rate. These two components might then be paid separately (if the procedure was performed in a hospital or another facility not owned by the physician) or together as one "global" rate (if the physician is on staff at the hospital or owns the facility).
- Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for radiology services. Medicaid last updated all radiology procedure codes January 1, 2008 to be priced at 90 percent of Medicare's 2008 non-facility fee schedule.

RHC

- Rural Health Clinic (RHC) services include primary care services, including physician services, services and supplies provided incident to a physician's services, nurse practitioner services, certified nurse midwife services, visiting nurse, clinical psychologist, certified social worker services and physician assistant services. Medicare designates a health clinic as an RHC if it is located in an area designated as a "shortage area." Shortage areas are defined geographic areas designated by the HHS as having either a shortage of personal health services or a shortage of primary medical care manpower. RHCs differ from FQHCs based on several criteria related to location, shortage area, corporate structure, requirements for a board of director and clinical staffing requirements.[95]
- Expenditures increased in SFY 2011 coinciding with an increase in recipients; however, because the increase in clients increased at a faster rate than the increase in expenditures, the per recipient expenditure decreased.
- RHC expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

[95] Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, US Department of Health and Human Services Health Resources and Services Administration, Revised June 2006. Available on-line: http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf

Table 1: RHC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,871,371	4,541	$ 412
2009	1,515,936	4,400	345
2010	1,710,855	4,671	366
2011	1,940,640	5,539	350
Percent Change SFYs 2010-2011	13.4	18.6	-4.3

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid reimburses RHC claims according to a prospective payment system (PPS) as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The PPS is based on 100 percent of a facility's average costs per encounter during SFY 1999 and SFY 2000. The rates are updated annually for inflation based on the MEI. The most recent increase was 0.4 percent effective January 1, 2011. In addition, adjustments may be made to rates if a provider requests a review of its rate based on a change to its scope of service. The per-encounter rate includes the office visit, as well as any ancillary services provided (x-rays, etc.).

Vision

- Medicaid covers the following vision services for recipients age 21 and over:
  - Treatment of eye disease or eye injury
  - Payment of deductible and/or coinsurance due on Medicare crossover claims for post surgical contact lenses and/or eyeglasses
  - Vision therapy for recipients receiving services from the ABI Waiver with qualifying medical diagnosis
- Medicaid also covers the following vision services for children under the age of 21:
  - Routine eye examinations, including determination of refractive state
  - Office exams, as medically necessary for the treatment of eye disease or eye injury
  - One pair of eyeglasses, replacement pairs when medically necessary and repairs when no longer under warranty

- One pair of standard frames per 12 month period, up to $76.00
- Corrective lenses
- Contact lenses for the correction of pathological conditions when useful vision cannot be obtained with regular lenses
- Vision therapy

- Vision therapy services can be performed by opticians, optometrists and ophthalmologists and are covered services under the ABI Waiver.[96] Vision therapy services, as identified by diagnoses codes, are capped at 32 visits per year. Medicaid considers additional visits or exceptions to the list of diagnosis codes identified as vision therapy on a case-by-case basis.
- Vision expenditures include services performed by optometrists, ophthalmologists and opticians.
- In SFY 2011, 94 percent of vision expenditures were for services provided by optometrists, 4 percent was for services provided by opticians and 2 percent was for services provided by ophthalmologists.
- Vision expenditures were less than one percent of total Medicaid expenditures in SFY 2011.

Table 1: Vision Services Total: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 2,621,023	11,935	$ 220
2009	2,945,895	12,911	228
2010	3,251,155	14,335	227
2011	3,286,215	14,700	224
Percent Change SFYs 2010-2011	1.1	2.5	-1.4

[96] See the ABI Waiver section for more information on the ABI Waiver.

Table 2: Ophthalmologist Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 41,190	286	$ 144
2009	59,519	491	121
2010	64,430	626	103
2011	58,670	579	101
Percent Change SFYs 2010-2011	-8.9	-7.5	-1.5

Table 3: Optometrist Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 2,466,067	11,493	$ 215
2009	2,762,647	12,224	226
2010	3,046,630	13,493	226
2011	3,103,713	13,867	224
Percent Change SFYs 2010-2011	1.9	2.8	-0.9

Table 4: Optician Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 113,767	695	$ 164
2009	123,729	759	163
2010	140,095	847	165
2011	123,831	818	151
Percent Change SFYs 2010-2011	-11.6	-3.4	-8.5

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- For ophthalmologists, Medicaid pays the lower of the provider's usual and customary charges or the Medicaid RBRVS fee schedule.[97] Opticians and optometrists receive the lower of charges or the fee specified in the Medicaid fee schedule.
- Providers bill for vision materials (i.e., frames and lenses) using HCPCS codes. Providers may also bill a dispensing fee for eyeglasses, but they may not receive reimbursement for the dispensing of frames, frame parts or lenses in addition to the eyeglass dispensing fee. Providers may not balance bill the recipient if the recipient chooses frames that are more expensive than the $76 limit set by Medicaid, unless there is a written agreement signed by the recipient and the provider.

Waivers

- Medicaid has six home and community based waivers and one Section 1115 waiver that have permission from the federal government to selectively "waive" one or more Medicaid requirements and subsequently allow for greater flexibility in the Medicaid program:
    - Child Developmental Disabilities (DD) Waiver
    - Adult Developmental Disabilities (DD) Waiver
    - Acquired Brain Injury (ABI) Waiver
    - Long Term Care (LTC) Waiver
    - Assisted Living Facility (ALF) Waiver
    - Children's Mental Health (CMH) Waiver
    - Pregnant by Choice Waiver (implemented in October 2008)

[97] For more information on the RBRVS fee schedule, refer to the Physician and Other Practitioners section.

SECTION 4: MEDICAID SERVICES & EXPENDITURES

- Medicaid, along with other Divisions within the Department of Health, oversees the various waiver service programs.
    - The Behavioral Health Division, formerly the Developmental Disabilities Division and Mental Health and Substance Abuse Services Division, manages the four Home and Community Based Services (HCBS) Waivers for children and adults with developmental disabilities, children with mental health needs, and individuals with an acquired brain injury.
    - Medicaid manages the two HCBS Waivers for LTC and ALF as well as the Pregnant by Choice Waiver.
- A detailed description of each waiver can be found in the sections that follow.
- In addition to services provided that are specific to each waiver, individuals enrolled in the waivers can receive other Medicaid services, with the exception of Pregnant by Choice Waiver individuals. These services are discussed as "non-waiver" services in the sections that follow.
- Expenditures for non-waiver services accounted for approximately 23 percent of all services paid by Medicaid for individuals enrolled in these seven waivers for SFY 2011.
- Each of the seven waivers contributes to the SFY 2011 expenditures for waiver and non-waiver services of $155 million.
- Expenditures for waiver services were 23 percent of total Medicaid expenditures in SFY 2011.

Table 1: Total Services for All Waiver Recipients, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 140,483,809	4,389	$ 32,008
2009	146,272,535	4,570	32,007
2010	146,455,713	5,068	28,898
2011	155,123,204	5,248	29,559
Percent Change SFYs 2010-2011	5.9	3.6	2.3

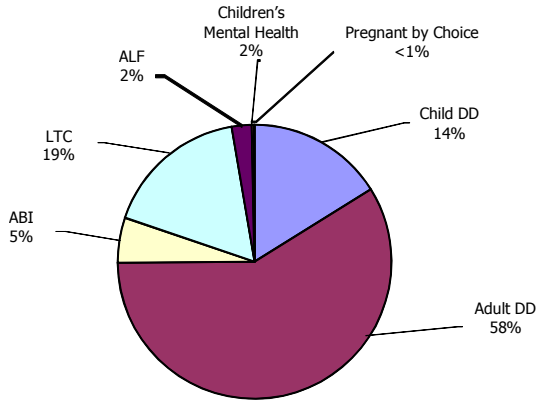
Table 2: Waiver Services Only for All Waivers, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 112,064,219	4,102	$ 27,319
2009	116,659,772	4,201	27,770
2010	113,399,950	4,777	23,739
2011	120,155,629	4,918	24,432
Percent Change SFYs 2010-2011	6.0	3.0	2.9

Table 3: Non-Waiver Services Only for All Waivers, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 28,419,589	4,271	$ 6,654
2009	29,612,764	4,403	6,726
2010	33,055,764	4,640	7,124
2011	34,967,575	4,708	7,427
Percent Change SFYs 2010-2011	5.8	1.5	4.3

Figure 1: Waiver and Non-Waiver Service Expenditures by Waiver, SFY 2011



Highlights and Developments

- The highlights and developments of each waiver are discussed in the sections that follow.

Reimbursement Methodology

- Medicaid reimburses waiver services differently depending on the waiver. The following sections describe the methodology for each in further detail.

Child DD Waiver

- The Behavioral Health Division (the Division) and Medicaid provide an array of services to children with DD. The Waiver was developed for children from birth up to age 21 with DD to assist them to receive training and support that will allow them to remain in their home communities and avoid institutionalization.
- Services provided under this waiver are:
    - Case management
    - Functional assessments
    - Respite
    - Personal care
    - Skilled Nursing
    - Dietician
    - Homemaker
    - Special family habilitation home
    - Child habilitation
    - Residential habilitation training
    - Specialized equipment
    - Environmental modifications
    - Supported living (ages 18-20)
    - Residential habilitation (ages 18-20)
    - Community integrated employment (ages 18-20)

  - Companion (ages18-20)
- For those choosing to self-direct services, the waiver also has:
  - Agency with Choice
  - Support Brokerage
  - Goods and Services
  - Unpaid Caregiver Training and Education
- The majority of services provided under this waiver are respite services. Waiver habilitation services assist individuals with developmental disabilities to improve self-help and socialization skills and skills related to activities of daily living.
- Non-waiver services comprised approximately 34 percent of all services received by children in the waiver in SFY 2011.
- Waiver and non-waiver expenditures for children with DD were 14 percent of total expenditures for all waivers in SFY 2011.

Table 1: Child DD Waiver Total Services, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 20,163,879	828	$ 24,353
2009	21,885,597	814	26,886
2010	22,644,643	834	27,152
2011	21,535,672	832	25,884
Percent Change SFYs 2010-2011	-4.9	-0.2	-4.7

Table 2: Child DD Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 12,876,621	796	$ 16,177
2009	14,451,370	755	19,141
2010	14,460,017	804	17,985
2011	14,128,741	799	17,683
Percent Change SFYs 2010-2011	-2.3	-0.6	-1.7

Table 3: Child DD Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 7,287,258	795	$ 9,166
2009	7,434,227	787	9,446
2010	8,184,626	802	10,205
2011	7,406,932	801	9,247
Percent Change SFYs 2010-2011	-9.5	-0.1	-9.4

Highlights and Developments

- The Division developed and implemented a "Quality Management Strategy" (QMS) for its HCBS Waivers that assesses the quality of waiver services provided throughout the state and assesses the effectiveness of the Division's administration of the waivers. The QMS, which has been approved by CMS, requires that the Division formally compile, analyze and report data and information relating to the waivers.[98]
- All of Wyoming's HCBS Waivers have growing waiting lists. Although the Wyoming Legislature has not placed limits on the number of individuals who can enroll in these waiver programs, the Wyoming Legislature has to approve funding for any expansion of these waiver programs. Funding has not been available to support the enrollment of all individuals who are eligible to enroll in the waiver program and who wish to do so. This is a concern to families and individuals waiting for services.

[98] Mikesell, C.E. and Malm K., "Report on Developmental Disabilities Division Adult Waiver Program," (October 1, 2006).

- The Division also notes that there are workforce shortages in several areas of the State, which limit the ability of providers to accept more clients. One factor contributing to the workforce shortages is competition for staff with the energy extraction industries. Additionally, some of the more rural communities lack providers. The Division has attempted to encourage access and choice by encouraging eligible family members and neighbors to become certified waiver service providers.
- Effective July 1, 2010 with the renewal of the waiver, the Child DD Waiver IBA is based upon the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Furthermore, there is a case review and Extraordinary Care Committee (ECC) process in place to review requests for IBA adjustments due to a change in client needs or emergencies.
- Participants may choose to self-direct waiver services from one of two Financial Management Service options, either a Fiscal Employer Agent or an Agency with Choice. Those self-directing their services through a Fiscal Employer Agent model will use a private Financial Management Service vendor that has been procured by the Division to complete payroll taxes and fulfill other IRS requirements, pay service providers, track the use of each individual's budget allocation and send monthly utilization reports to the waiver participant and his or her case manager.
- Those participants and guardians self-directing their HCBS waiver services will be provided with a range of wages (developed using the state's labor statistics) that would be appropriate to pay their hired employees. Additionally, for those using the Agency with Choice model to self-direct their services, a new rate schedule has been developed to pay for services, which considers the required administrative fees of the Agency with Choice.[99]
- Effective July 1, 2010, a 6% restoration of the SFY 2010 10% rate reduction was implemented for the Child DD Waiver as well as the Adult DD and ABI Waivers.

Reimbursement Methodology

- Medicaid reimburses based on a cost-based fee schedule with tiered rates for residential and day habilitation services based upon assessed needs. All other services have one standardized rate.
- Medicaid reimburses for waiver services as part of each consumer's Individualized Budget Amount (IBA), which covers all waiver services (e.g., respite, case management, personal care, habilitation services, among other services). Under the IBA approach, Medicaid allocates a set amount of funding to each consumer based on individual characteristics and his or her service utilization.
- For the Child DD Waiver, IBA determination is calculated based upon historical service units used multiplied by the current rates for those services. If a participant's IBA is not meeting his or her needs, an IBA adjustment request is submitted by the person's case manager and reviewed by the Division. For extraordinary care needs, the ECC committee reviews the full service and support structure of a person, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the person's assessed needs.

[99] The Agency with Choice model allows waiver participants to have an increased level of self-determination while assuming shared responsibility with a service provision agency for the hiring and management of the employees who provide the waiver services. The Agency with Choice model designates the waiver participant or their legal representative as the managing employer while the service providing agency is the" Agency with Choice" and becomes the common law employer of record.

Adult DD Waiver

- Similar to the Child DD Waiver, the Division and Medicaid also provide an array of services to adults with DD. The Waiver was developed to assist adults to receive training and support that will allow them to remain in their home communities and avoid institutionalization.
- Services provided under this waiver are:
    - Case management
    - Functional assessments
    - Respite
    - Personal care
    - Skilled Nursing
    - Dietician
    - Supported Living
    - Residential habilitation
    - Day habilitation
    - Specialized equipment
    - Environmental modifications
    - Supported employment
    - Occupational, physical and speech therapies
    - Companion (ages 18-20)
- For those choosing to self-direct services, the waiver also has:
    - Agency with Choice
    - Support Brokerage
    - Goods and Services
    - Unpaid Caregiver Training and Education
- The largest volumes of services that are provided under the Adult DD Waiver are: Residential Habilitation, and Day Habilitation Services.
- Non-waiver services comprised approximately 9 percent of all services received by adults in the waiver in SFY 2011.
- HCBS waiver and non-waiver expenditures for adults with DD were 58 percent of total expenditures for all waivers in SFY 2011.

Table 1: Adult DD Waiver Total Services, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 87,154,794	1,348	$ 64,655
2009	89,525,581	1,352	66,217
2010	83,183,518	1,375	60,497
2011	89,288,685	1,394	64,052
Percent Change SFYs 2010-2011	7.3	1.4	5.9

Table 2: Adult DD Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 80,204,977	1,299	$ 61,744
2009	81,815,516	1,301	62,887
2010	75,746,359	1,336	56,696
2011	81,369,215	1,355	60,051
Percent Change SFYs 2010-2011	7.4	1.4	5.9

Table 3: Adult DD Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 6,949,817	1,311	$ 5,301
2009	7,710,065	1,321	5,837
2010	7,437,159	1,336	5,567
2011	7,919,471	1,367	5,793
Percent Change SFYs 2010-2011	6.5	2.3	4.1

Highlights and Developments

- The highlights and developments related to the Adult DD Waiver is the same as that discussed in the Child DD Waiver section.
- The Division provides annual reports to CMS, which verify that Wyoming is meeting the six assurances required by CMS, relating to the level of care, service plan, qualified providers, health and welfare, administrative authority and financial accountability.

Reimbursement Methodology

- The reimbursement methodology used for the Adult DD Waiver is similar to that discussed in the Child DD Waiver section.
- For the Adult DD Waiver and Acquired Brain Injury Waiver, the IBA is based upon the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. This change was implemented as a result of the new rate methodology which caused the prior IBA determination using the "DOORS" funding model to no longer be viable. Furthermore, there is a case review and Extraordinary Care Committee (ECC) process in place to review requests for IBA adjustments due to a change in client needs or emergencies.

ABI Waiver

- The Division and Medicaid also provide an array of services to adults with an acquired brain injury (ABI). The ABI Waiver was developed for adults from ages 21 to 65 with ABI and assists adults to receive training and support that will allow them to remain in their home communities and avoid institutionalization.

- Services provided under this waiver are:
  - Case management
  - Functional assessments
  - Respite
  - Personal care
  - Nursing
  - Dietician
  - Supported Living
  - Residential habilitation
  - Day habilitation
  - Specialized equipment
  - Environmental modifications
  - Supported employment
  - Occupational, physical and speech therapies
  - Cognitive retraining
  - Companion (ages 18-20)
- For those choosing to self-direct services, the waiver also has:
  - Agency with Choice
  - Support Brokerage
  - Goods and Services
  - Unpaid Caregiver Training and Education
- Non-waiver services comprised approximately 18 percent of all services received by recipients with ABI in the HCBS waiver in SFY 2011.
- Waiver and non-waiver expenditures for recipients with ABI were 5 percent of total expenditures for all waivers in SFY 2011.

Table 1: ABI Waiver Total Services, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 7,026,672	185	$ 37,982
2009	7,265,159	177	41,046
2010	7,679,186	201	38,205
2011	8,529,077	186	45,855
Percent Change SFYs 2010-2011	11.1	-7.5	20.0

Table 2: ABI Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 5,884,610	180	$ 32,692
2009	6,058,440	161	37,630
2010	6,243,946	192	32,521
2011	6,963,271	177	39,341
Percent Change SFYs 2010-2011	11.5	-7.8	21.0

Table 3: ABI Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 1,142,062	176	$ 6,489
2009	1,206,719	170	7,098
2010	1,435,240	198	7,249
2011	1,565,807	180	8,699
Percent Change SFYs 2010-2011	9.1	-9.1	20.0

Highlights and Developments

- The highlights and developments related to the ABI Waiver is the same as that discussed in the Child DD Waiver section.
- The Division provides annual reports to CMS, which verify that Wyoming is meeting the six assurances required by CMS, relating to the level of care, service plan, qualified providers, health and welfare, administrative authority and financial accountability.
- Additionally, those who choose to self-direct through the Agency with Choice model will assume shared responsibility with a service provision agency for the hiring and management of the employees who provide the waiver services. The Agency with Choice model designates the waiver participant or their legal representative as a co-employer (managing employer) while the service providing agency, the ”Agency with Choice”, becomes the common law employer.

Reimbursement Methodology

- The reimbursement methodology used for the ABI Waiver is similar to that discussed in the Adult DD Waiver section.

LTC Waiver

- Medicaid provides long-term care services through a Long-term Care (LTC) Waiver. Wyoming's LTC Waiver provides in-home services to recipients 19 years of age and older who require services equivalent to a nursing facility level of care.
- Services provided under this waiver are:
    - Case management
    - Personal care
    - Respite
    - Adult day care
    - Non-medical transportation
    - Personal emergency response system
    - Home-delivered meals
    - Skilled nursing care
- The LTC Waiver includes a Consumer-Directed Care option for recipients who are capable of directing their own care. This option allows recipients to recruit, hire, train, schedule, evaluate and terminate their own personal care assistants.
- Medicaid requires a functional assessment to determine medical necessity for LTC Waiver services. Medicaid will not reimburse for services to an individual who has not met the level of care assessment criteria.
- There were 1,985 LTC Waiver recipients in SFY 2011. This was more than the 1,450 available waiver slots in SFY 2011 because a certain portion of the waiver recipients leave the waiver program and are replaced by new recipients.
- Non-waiver services comprised approximately 52 percent of all services received by LTC waiver recipients in SFY 2011.
- LTC waiver and non-waiver expenditures were 19 percent of total expenditures for all waivers in SFY 2011.

Table 1: LTC Waiver Total Services for Waiver Recipients, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 22,688,488	1,779	$ 12,754
2009	24,219,716	1,873	12,931
2010	27,670,091	1,974	14,017
2011	29,284,684	1,985	14,753
Percent Change SFYs 2010-2011	5.8	0.6	5.2

Table 2: LTC Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 10,260,118	1,618	$ 6,341
2009	12,088,839	1,682	7,187
2010	13,424,332	1,822	7,368
2011	13,912,032	1,809	7,690
Percent Change SFYs 2010-2011	3.6	-0.7	4.4

Table 3: LTC Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 12,428,370	1,749	$ 7,106
2009	12,130,878	1,840	6,593
2010	14,245,758	1,940	7,343
2011	15,372,652	1,945	7,904
Percent Change SFYs 2010-2011	7.9	0.3	7.6

Highlights and Developments

- In SFY 2011, the waiting list increased by 62 persons with a waiting period of 3 months or less.
- Medicaid submitted the Waiver renewal to CMS the end of March 2011, which was approved effective July 1, 2011 for the next five years.
- Medicaid is strengthening the quality assurance component of the waiver program by increasing provider accountability and developing internal processes to gather data to evaluate strengths and weaknesses.

Reimbursement Methodology

- Each LTC Waiver recipient has a plan of care prepared by a case manager and a budget for the required services that is approved by the Division of Healthcare Financing. Medicaid limits the dollar amount of the plan of care to the maximum amount allowed for the approved services, which must be less than the cost of Medicaid nursing facility care.
- Medicaid reimburses providers according to the lower of the fee schedule or the provider's usual and customary charges. Medicaid funds the waiver through Wyoming Legislative appropriation based on the cost per client in the previous two-year period. The Wyoming Legislature considers increases as exception budget requests.

ALF Waiver

- Medicaid provides long-term care services through an Assisted Living Facility (ALF) Waiver.
- The ALF Waiver allows recipients 19 years of age and older who require services equivalent to a nursing facility level of care to receive services in an ALF. Each waiver recipient has a plan of care prepared by a case manager.

SECTION 4: MEDICAID SERVICES & EXPENDITURES

- Medicaid requires a functional assessment to determine medical necessity for ALF Waiver services. Medicaid will not reimburse for services to an individual who has not met the level of care assessment criteria.
- Non-waiver services comprised approximately 21 percent of all services received by ALF Waiver recipients in SFY 2011.
- ALF waiver and non-waiver expenditures were two percent of total expenditures for all waivers in SFY 2011.

Table 1: ALF Waiver Total Services for Waiver Recipients, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 3,255,179	236	$ 13,793
2009	2,652,809	243	10,917
2010	3,670,483	263	13,956
2011	3,497,432	253	13,824
Percent Change SFYs 2010-2011	-4.7	-3.8	-0.9

Table 2: ALF Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 2,828,859	203	$ 13,935
2009	2,156,841	210	10,271
2010	3,058,800	236	12,961
2011	2,757,617	217	12,708
Percent Change SFYs 2010-2011	-9.8	-8.1	-2.0

Table 3: ALF Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 426,319	227	$ 1,878
2009	495,967	240	2,067
2010	611,682	253	2,418
2011	739,815	244	3,032
Percent Change SFYs 2010-2011	20.9	-3.6	25.4

Highlights and Developments

- In SFY 2011, the waiting list increased by 18 persons with a waiting period of 2 months or less. There are now 15 ALFs across Wyoming providing services for the ALF Waiver. This has allowed more choice and access for waiver participants.
- Medicaid is strengthening the quality assurance component of the waiver program by increasing provider accountability and developing internal processes to gather data to validate strengths and weaknesses.

Reimbursement Methodology

- Medicaid reimburses for ALF nursing care provided by the facility at a per diem rate determined by the functional assessment score. The per diem pays for the required personal care, 24-hour supervision and medication assistance up to a yearly or monthly cap. Medicaid also reimburses a separate fee for case management services. ALF recipients pay their own room and board.
- Medicaid funds the waiver through Wyoming Legislative appropriation based on the cost per client in the previous two-year period. The Wyoming Legislature considers increases as exception budget requests.

CMH Waiver

- Medicaid implemented the Children's Mental Health (CMH) Waiver program in July 2006. The goal of the waiver is to allow youth with serious emotional disturbance who need mental health treatment to remain in their home communities. Waiver recipients must be between the ages of 4 and 20, have needs that meet the definition of serious emotional disturbance, be financially eligible for Medicaid and meet specific clinical criteria. Children's Mental Health Waiver recipients receive all Medicaid services while participating in the waiver program.

- Each recipient has an Individualized Service Plan and budget developed by a team of providers and the child's family. Waiver recipients receive non-clinical services as outlined in an Individual Service Plan, including family care coordination, youth and family training and support, and respite.
- Due to the increased visibility and statewide availability of the CMH Waiver, there has been an increase of 160 recipients since 2008.
- There were 173 CMH Waiver recipients in SFY 2011, which was a 56 percent increase from SFY 2010.
- A major component to the expenditure increase was availability of waiver providers across the State.
- Children's Mental Health Waiver expenditures were approximately two percent of total expenditures for all waivers in SFY 2011.

Table 1: Children's Mental Health Waiver Services, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 194,797	13	$ 14,984
2009	711,685	45	15,815
2010	1,533,159	111	13,812
2011	2,881,354	173	16,655
Percent Change SFYs 2010-2011	87.9	55.9	20.6

Table 2: Children's Mental Health Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 9,034	6	$ 1,506
2009	76,778	26	2,953
2010	391,862	77	5,089
2011	918,455	136	6,753
Percent Change SFYs 2010-2011	134.4	76.6	32.7

Table 3: Children's Mental Health Non-Waiver Services Only, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 185,763	13	$ 14,289
2009	634,908	45	14,109
2010	1,141,297	111	10,282
2011	1,962,899	171	11,479
Percent Change SFYs 2010-2011	72.0	54.1	11.6

Highlights and Developments

- Medicaid is continuing to target children who may be eligible for the waiver, and developing a provider base which can provide better High Fidelity Wraparound facilitation for the waiver services. This development has included coaching for a pilot group of Family Care Coordinators (FCC). When the coaching process is complete, the FCC will be credentialed in the High Fidelity Wraparound process.
- The Children's Mental Health Waiver program continues to collaborate with peers from DFS, Community Mental Health Centers and other statewide stakeholders to deliver High Fidelity Wraparound training as wraparound is the process that supports successful outcomes for children with complex needs.
- Medicaid will focus on developing the availability of respite service to waiver recipients due to the fact that respite providers continue to be sparse across the State.

Reimbursement Methodology

- Medicaid reimburses for waiver services according to the lower of the provider's usual and customary fee or the fee specified in the Medicaid fee schedule. Medicaid evaluated and modified reimbursement rates to support cost neutrality within the waiver.

Pregnant by Choice Waiver

- Medicaid provides pregnancy planning services through Section 1115 Medicaid waiver program called Pregnant by Choice. Pregnant by Choice is a five-year demonstration that is effective from October 1, 2008 through September 30, 2013. This program provides family planning services and birth control options to women who have received Medicaid benefits through the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth. Overall, the goal of the waiver is to reduce the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies with the intent of reducing health risks to women and children and achieving a cost savings.
- Services provided under this waiver are targeted to women and include:
    - Initial physical exam and health history
    - Annual follow-up exam for reproductive health/family planning purposes
    - Follow-up office visits related to family planning
    - Contraceptive management including prescriptions, devices and supplies insertion implantation, or injection of contraceptive drugs or devices
    - Removal of contraceptive devices
    - Sterilization services
    - Necessary family planning/reproductive health-related laboratory procedures, diagnostic tests and medications
- Pregnant by Choice Waiver expenditures are not linked to a specific provider type. Therefore, expenditures discussed in this section are already reported in the FQHC, Prescription Drugs and Physicians and Other Practitioners sections. For this reason, expenditures identified as Pregnant by Choice Waiver expenditures are excluded from the Introduction section of this Report.
- Medicaid implemented the waiver on January 1, 2009; therefore, expenditures for SFY 2009 represent six months of activity.
- Pregnant by Choice Waiver expenditures were less than one percent of total expenditures for all waivers in SFY 2011.

Table 1: Pregnant by Choice Waiver Services, Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Expenditures Per Recipient (C)=(A/B)
2008	$ 0	0	$ 0
2009	11,987	66	182
2010	74,633	310	241
2011	106,300	425	250
Percent Change SFYs 2010-2011	42.4	37.1	3.9

Highlights and Developments

- There were no highlights and developments for SFY 2011 for this service area.

Reimbursement Methodology

- Medicaid reimburses for waiver services according to the lower of the provider's usual and customary fee or the fee specified in the Medicaid fee schedule. The following providers serve recipients of the Pregnant by Choice waiver:
  - Family Planning Clinics
  - Primary Care Physicians (MDs and DOs) in public and private practice
  - Certified Nurse Midwives
  - Nurse Practitioners
  - Physician Assistants
  - Pharmacies
  - Laboratories
  - Outpatient Departments of Hospitals (as appropriate)
  - Federally Qualified Health Centers
  - Rural Health Clinics
  - Indian Health Services

Program Integrity

- The Medicaid Program Integrity Unit (the Unit) is responsible, through a coordinated process of education, reviews, audits and appropriate corrective action plans, for ensuring the integrity and accountability of all payments made for healthcare services on behalf of a recipient. These activities are required under *42 CFR Section 455* (Program Integrity: Medicaid) and 456 (Utilization Control).
- Other divisions within the Department of Health maintained control over certifying providers, but the Unit conducted all reviews and audits of providers and assisted in sanctioning of providers.

Table 1: Summary of Medicaid Program Integrity Cases and Recoveries

Taxonomy	Description	Number of Cases Opened in SFY 2011	Amount of Claims Reviewed	Number of Providers Recovered	Amount Recovered
103TC0700X	Clinical Psychologist	1	315.85	0	0.00
122300000X	Dentist	0	0.00	0	0.00
1223G0001X	Dentist - General Practice	0	0.00	0	0.00
1223P0221X	Pedodontics	0	0.00	0	0.00
1223X0400X	Orthodontics	0	0.00	0	0.00
152W00000X	Optometrist	1	267.00	0	0.00
207K00000X	Allergy	0	0.00	0	0.00
207L00000X	Anesthesiology	0	0.00	0	0.00
207N00000X	Dermatology	0	0.00	0	0.00
207P00000X	Emergency Medicine	0	0.00	0	0.00
207Q00000X	Family Practice **	2	22,864.99	1	7,071.53
207R00000X	Internal Medicine	0	0.00	0	0.00
207RC0000X	Internal Medicine, Cardiovascular	0	0.00	0	0.00
207RE0000X	Internal Medicine, Endocrinology	0	0.00	0	0.00
207RG0100X	Internal Medicine, Gastroenterology	0	0.00	0	0.00
207RG0300X	Internal Medicine, Geriatric Medicine	0	0.00	0	0.00
207T00000X	Neurology Surgery	0	0.00	0	0.00
207V00000X	Obstetrics/Gynecology	3	3,117.31	0	0.00
207W00000X	Ophthalmology	0	0.00	0	0.00
207X00000X	Orthopedic Surgery	1	6,668.00	0	0.00
207ZP0105X	Pathology	0	0.00	0	0.00
208000000X	Pediatrics	0	0.00	0	0.00
2080N0001X	Pediatrics, Neonatal-Perinatal	2	155.28	0	0.00
2084P0800X	Psychiatry & Neurology - Psychiatry	2	367.29	0	0.00
2085R0202X	Diagnostic Radiology	1	39.42	0	0.00
208800000X	Urology	0	0.00	0	0.00
208D00000X	Physician - General Practice	0	0.00	0	0.00

SECTION 5: PROGRAM INTEGRITY

Taxonomy	Description	Number of Cases Opened in SFY 2011	Amount of Claims Reviewed	Number of Providers Recovered	Amount Recovered
225100000X	Physical Therapist	0	0.00	0	0.00
225X00000X	Occupational Therapist	0	0.00	0	0.00
251B00000X	LTC – Waiver *	4	22,450.25	1	570.00
251C00000X	DDD Waiver ***	107	1,811,164.79	69	65,073.69
251E00000X	Home Health	2	6,911.00	1	364.00
251G00000X	Hospice Care; Community Based	0	0.00	0	0.00
251K00000X	Public Health	4	480.00	0	0.00
261Q00000X	Clinic/Center	0	0.00	0	0.00
261QA1903X	Ambulatory Surgical Center	0	0.00	0	0.00
261QF0400X	Federally Qualified Health Center	5	779,140.37	1	777,763.80
261QM0801X	Community Mental Health Center	19	39,082.36	15	12,464.71
261QP0904X	Public Health - Federal	1	3,962.00	0	0.00
261QR0405X	Substance Abuse Centers	2	1,333.25	1	19.00
261QR1300X	Rural Health	6	1,171.66	0	0.00
275N00000X	Swing Bed	0	0.00	0	0.00
282N00000X	General Acute Care Hospital	111	5,228,063.63	1	134,273.62
282NR1301X	General Acute Care Hospital - Rural	23	322,194.22	0	0.00
283Q00000X	Psychiatric Hospital	0	0.00	0	0.00
283X00000X	Rehabilitation Hospital	9	309,117.56	0	0.00
291U00000X	Clinical Medical Laboratory	0	0.00	0	0.00
314000000X	Nursing Facility	8	44,258.42	2	13,872.83
315P00000X	Intermediate Care Facility, MR	2	20,391.28	0	0.00
322D00000X	Residential Treatment Facility	1	6200.00	0	0.00
323P00000X	Psychiatric Residential Treatment Facility	16	190,292.00	0	0.00
332B00000X	Durable Medical Equipment & Supply	1	472.80	0	0.00
333600000X	Pharmacy	30	16,816.78	23	6,660.27
335E00000X	Orthotics/Prosthetics	0	0.00	0	0.00
341600000X	Ambulance *	1	970.63	1	970.63
363LF0000X	Nurse Practitioner - Family Health	0	0.00	0	0.00
364SP0808X	Advance Practice Nurse ***	0	0.00	0	0.00
		365	**8,838,268.14**	**129**	**1,016,928.76**

*Terminated one provider in each group
** Terminated two providers in each group
***Terminated three providers in each group

Medicaid Program Integrity

- The Unit is comprised of nine staff members. The team consists of the Program Integrity Manager, Program Integrity Supervisor, Program Integrity Enforcement Supervisor, Third Party Liability/Recovery Coordinator, Health Programs Specialist, Investigative Analyst and three Program Integrity Enforcement Specialists. The Unit works closely with the fiscal agent's Medical Policy Unit, the Quality Improvement Organization, as well as the program managers of Medicaid. The Unit also collaborates with MFCU, located in the Attorney General's Office and the Office of Inspector General (OIG).
- The process that the Unit follows includes:
    - Receive referrals from providers, individuals, Department of Health staff, Medicaid's fiscal agent staff, and through data mining and Explanation of Benefits (EOBs)
    - Research and investigate the referral by requesting documentation of the medical service
    - Update Medicaid policy and address claims processing issues
    - Educate providers and recipients
    - Collect recoveries from individuals for claims that do not have sufficient documentation or that were billed incorrectly
    - Make additional referrals to law enforcement, licensing and certifying boards, MFCU and DFS Prosecution, Recovery, Investigation, Collection Enforcement Program (PRICE)
- The Unit implemented an electronic information system that is known as the Enterprise Fraud and Abuse Detection System (EFADS). Complementary applications of the fraud and abuse solution are Enterprise Fraud Analytics (EFA) and Enterprise Surveillance and Utilization Review (ESUR). These components assist the Unit to identify potential fraud and abuse and speed the recovery of Medicaid dollars.
- The EFA is a suite of comprehensive analytical tactics customized to Medicaid that applies advanced technologies to detect suspect medical claims, non-compliance, fraud, abuse, and waste. The purpose of EFA is to analyze data provided by the MMIS using filters to identify outliers in the data. The outlier information can then be further researched. Filters are activity-specific, that is they electronically search and screen for specific types of potentially fraudulent behavior. Filters are continually added that detect or screen for specific activities or changing trends in fraudulent behaviors. Additionally, Medicaid staff scrutinizes filters and periodically modifies them to retain optimal effectiveness.
- The ESUR component of EFADS incorporates peer-to-peer comparisons. This compares providers to detect and report aberrant behavior.
- Although the Unit is primarily responsible for policing fraud and abuse in Medicaid, CMS provides technical assistance, guidance and oversight for these efforts.
- The Deficit Reduction Act (DRA) of 2005 included three provisions that address Medicaid program integrity and target fraud and abuse. The CMS Medicaid Integrity Program, as established by Section 6034 of the DRA, provides more resources to fight Medicaid fraud, waste and abuse. Section 6031 of the DRA creates financial incentives for State fraud and abuse laws. Finally, Section 6032 of the DRA requires any entity that receives or makes payments under the State Medicaid program of at least $5,000,000 annually, to provide False Claims Act education to their employees.
- The Unit opened 365 cases with 4,646 claim records. Claims and service activities were reviewed on these cases. Some reviews resulted in recoveries of a portion or all of the claims reviewed. Others may still be in process or determined that a recovery was not warranted.

- The Unit expects to perform more provider claim reviews and provide more education to providers about Medicaid policy. The increase in reviews is due to several on-going audit activities, the A-133 Compliance Audit, the Payment Error Rate Measurement (PERM) and the Medicaid Integrity Contractors (MIC) audit.
- An accounting firm annually conducts the A-133 Compliance Audit as required by the Office of Management and Budget (OMB). The purpose of the audit is to review the operations of Medicaid as a non-Federal entity that receives greater than $300,000 in Federal funding.
- Federal contractors conduct the PERM audits every three years. PERM audits determine the accuracy of claims payments and eligibility by reviewing a random sample of claims data, eligibility data and medical records. The OMB publishes the error rate for Wyoming and 16 other states in the OMB Performance and Accountability Report (PAR).
- The purpose of the MIC audit is to review Medicaid providers, identify overpayments and provide education on payment integrity and quality of care issues. The MIC runs algorithms on Medicaid claims data to select providers to audit. Some audits will be desk audits where the provider will send the records into the contractor and some audits will be conducted in the field at the provider's business.

Third-Party Liability, Estate and Other Recovery

- The TPL program is vigorously involved in activities which keep Medicaid as the payer of last resort through cost avoidance and benefit recovery.
- The TPL and Estate Recovery Programs keep Medicaid as the payer of last resort by identifying legally obligated parties, for example health insurance companies, casualty carriers, Medicare, class actions or products liability, probate estates and non-probate estates who have a responsibility to pay for medical services and claims prior to Medicaid. Also, TPL recovers drugs rebates for certain physician administered drugs from drug manufacturers (J-code rebates). During SFY 2011 third-party liability functions lead to costs avoided of $13,016,101.69, health insurance and Medicare recoveries of $1,237,438.56, TPL subrogation/casualty recoveries of $1,589,473.99, estate recoveries of $1,539,091.20, and J-code rebates collected of $1,332.258.56.
- Medicaid, in cooperation with its fiscal agent and two contract attorneys, continue to strive to improve the effectiveness and efficiency of cost avoidance, third party recovery, and estate recovery. Activities include:
    - Increasing recoveries for the J-code rebate program. In SFY 2010, J-code rebates collected totaled $485,503.95. However, J-code rebates collected in SFY 2011 increased to $1,332,258.56.
    - Establishing data matches with County Clerks of the District Court for civil actions filed in their counties. Currently, Medicaid has data matches with Laramie County, Albany County, Natrona County, Uinta County, Sheridan County, Teton County, and Park County. Medicaid will be working with the other counties Clerks of the District Court in the coming year to try to establish data matches with them which will potentially lead to more TPL cases.
    - Reviewing current system functions to verify that cost avoidance of medical services and claims occurs wherever possible.

Pharmacy Program Integrity

- Pharmacy program integrity efforts are focused on maintaining accurate and adequate payments to pharmacy providers while minimizing payments for fraudulent claims and/or system or billing errors. Pharmacy Program Integrity efforts for SFY 2011 have included:
    - Quarterly review of all pharmacy paid claims over $500
    - Quarterly review of all paid claims for prescriptions after the death of a recipient
    - Quarterly review of all paid claims paid with a Dispense as Written code of (1)
    - Intermittent review of claims referred from various entities including:
        - Random claim reviews by Pharmacy Program Integrity staff
        - Law enforcement
        - Various Department of Health staff
        - Pharmacy & Therapeutics Committee
        - Wyoming Board of Pharmacy
        - Wyoming Board of Medicine
        - Drug Enforcement Agency
        - Drug Rebate staff (State and vendors), as well as CMS
    - Review and recommendations regarding changes and updates needed to maximize efficiency and accuracy of the pharmacy point-of-sale claims payment systems
    - Increased Pharmacy Benefit Manager (PBM) clinical claims reviews
    - Comprehensive pharmacy auditing plan with efforts focused on:
        - Patient EOB letters providing current claim information, mailed to patients. These letters are used to determine whether the patient actually received the services billed to Medicaid and to uncover claims payments that should not have been reimbursed.
        - Ongoing desk audits of pharmacies to evaluate accuracy of claims payments and follow-up from EOB mailing results.
- Other program integrity efforts have included the pharmacy lock-in program to support appropriate use of narcotic pain medications and pharmacy-specific fraud and abuse detection.[100] This program is intended to prevent Medicaid recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

Table 1: Pharmacy Program Integrity — SFY 2011

Program Area	Third-Party Payment Avoidance
Third-Party Liability Payment Avoidance on Prescription Claims	$ 4,822,350
Prescription Claims Recoveries	44,222
Total Pharmacy Program Integrity Cost Containment Measures	**$ 4,866,572**

[100] Medicaid may restrict or "lock-in" recipients to a certain provider if the recipient's utilization of services is documented as being excessive.

Initiatives and Subprograms

- Medicaid has undertaken a number of initiatives and implemented subprograms to meet federal or State government mandates, to meet the specific medical needs of Medicaid recipients and to give recipients better access to care or more care options. While these initiatives and subprograms are carried out in conjunction with the service areas described in the preceding sections, there are specific features of these initiatives and subprograms that warrant separate discussion.

Community Oral Health Coordinator Program

- Medicaid launched the Community Oral Health Coordinator (COHC) program, a county-based program that employs a dental hygienist to perform oral health screenings for children 6 months to 5 years regardless of Medicaid eligibility. The Oral Health Coordinator also performs outreach and education, distributes publicity regarding oral disease prevention and links children and families to appropriate oral health services. In SFY 2011 the program provided dental screening for 11,832 children and referred 2,730 children for dental treatment.
- In SFY 2011, counties served by the COHC decreased by two. The counties affected are being provided limited programs by the COHC from the neighboring county. The COHC also work with physician offices to promote the physician's participation in the application of fluoride varnish for children on Medicaid. In 2011 the COHC conducted fluoride mouth rinse programs in classrooms and fluoride varnish applications for 4,637 children. Fluoride varnish applications were given 3 times per year for children at high risk for tooth decay.

Drug Utilization Review (DUR) Program

- Medicaid established a DUR program in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). The program reviews utilization of outpatient prescription drugs to ensure Medicaid recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects. The Medicaid Pharmacy Program has contracted with the University of Wyoming to administer the program. The program includes a number of activities, as described in the following sections.

Pharmacy and Therapeutics Committee

- The Pharmacy & Therapeutics (P&T) Committee is comprised of six physicians, five pharmacists, and one allied health professional. All members are actively practicing in the State of Wyoming. Ad hoc members include the Medicaid Medical Director, State Pharmacist, Pharmacy Program Manger, Pharmacist Consultant, and two drug information specialists from the University of Wyoming School of Pharmacy. The P&T Committee meets four times per year to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to the Medicaid Pharmacy Program.

Prospective DUR

- The DUR program is required to review prescription claims for appropriateness prior to dispensing at the pharmacy. Prior authorization (PA) policies are also taken into consideration. This review identifies

potential issues such as therapeutic duplication, drug-disease contraindications, drug-drug interactions, potential adverse effects and others. For FFY 2010, total cost avoidance from DUR activities totaled $11,552,338.[101]

Retrospective DUR

- Retrospective DUR is the ongoing review of utilization to monitor for therapeutic appropriateness, over- and underutilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions and others. This review takes place through examination of aggregate claims data to uncover trends, as well as review of individual patient profiles. Review of aggregate claims data can lead to recommendations for prospective DUR policy, including PA, to encourage appropriate utilization at the program level. Review of individual patient profiles may result in educational letters to the prescriber when the reviewing Committee members determine the issue to be clinically significant to a specific patient.

Education

- The DUR program sends bimonthly newsletters to all Wyoming providers. In addition, the program sent targeted education letters regarding:
    - Prolonged use of Bisphosphonates
    - Appropriate use of anti-emetics
    - Gabapentin use for headaches and sleep
- In March 2011, the Wyoming Drug Utilization Review Program, in cooperation with the Wyoming Board of Medicine, Wyoming Workers' Compensation, and Federation of State Medical Boards, provided a copy of *Responsible Opioid Prescribing: A Physician's Guide* to 1,391 Wyoming physicians and 221 Wyoming physician assistants.

Review of Clinical Evidence

- The P&T Committee is responsible for reviewing evidence regarding the comparative safety and efficacy of medications. The Committee makes recommendations to the Medicaid Pharmacy Program regarding the comparative safety and efficacy of each reviewed class, and provides input on clinical considerations that are included in the creation of the Medicaid Preferred Drug List.

Input from the Medical Community

- The DUR Program receives input from the Wyoming Medical Community in several ways:
    - The Psychiatrist Advisory Board (PAB) consists of five psychiatrists. The working group provides focused recommendations to the P&T Committee regarding utilization of psychiatric medications in the Medicaid population.
    - The DUR Program actively solicits feedback about PA policies from prescribers in Wyoming through direct mailings. The letters are sent to all specialists in the affected area as well as a random sample of fifty general practitioners. The P&T Committee reviews all comments that are received prior to giving final approval of the policy. This is an important step in the DUR process which allows providers an opportunity to participate in the decision-making process.

[101] FFY 2010 is the most recently available data at the time this document was updated.

Health Check

- Medicaid operates the Health Check program, formerly known as EPSDT services. Health Check is a program for children ages birth through 20 years old that provides the following benefits:
    - Physical exams
    - Immunizations
    - Lab tests (blood tests and lead screening)
    - Growth and developmental check
    - Nutrition check
    - Eye exam
    - Hearing screening
    - Dental screening
    - Health information
    - Mental/behavioral health assessment
    - Other healthcare prescribed by a physician and approved by Medicaid
    - Teen-age health education
    - Transportation (ambulance and administrative)
- Medicaid will pay for all Health Check screening exams and authorized follow-up care and treatment as long as the child is eligible for Medicaid.

Long-Term Care Partnership Program

- In collaboration with the Department of Insurance, Medicaid developed the Long-Term Care Partnership Program (LTCP) to finance long-term care in Wyoming. The program provides outreach and education to middle and high-income individuals regarding planning for one's future long-term care needs. The program also allows these individuals to purchase a qualified LTCP policy. It is anticipated that over time the LTCP could reduce the need for medical assistance expenditures for long-term care institutional or waiver service in Wyoming. To encourage individuals to purchase a LTCP policy, a dollar for dollar resource disregard will be applied toward Medicaid eligibility determination. For each dollar paid from a LTCP policy, a dollar will be disregarded when applying for Medicaid. The dollar amount disregarded during eligibility determination will also be disregarded from estate recovery. The applicant will still need to meet resource guidelines for Medicaid eligibility determination.

Administrative Transportation Services

- Medicaid will cover the cost of transportation to and from medical appointments, (administrative transportation), if all three criteria below are met:
    - The medical appointment must be medically necessary.
    - Transportation must be approved at least three business days in advance by the Department.[102]
    - The least costly mode of transportation must be selected.

[102] Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided.

- Medicaid will choose the appropriate mode of transportation based on expense and reasonable availability, which includes public transportation, private automobile, taxi, bus, shuttle service and airline.
- In addition to the cost of transportation, per diem expenses are reimbursable to the recipient or his or her legal guardian if the recipient is under age 21 and the services to be received are expanded services. Reimbursement for per diem expenses is limited to $25 per day, to be used for meals and commercial lodging.

Project Out

- Project Out is a temporary short-term Medicaid and state-funded intervention and assistance program that helps consumers overcome the barriers to living independently in the community. The program provides targeted case management and limited financial resources to assist with some of the costs of transitioning out of or diverting from a nursing home. Costs might include moving or storage expenses, rental or utility deposits, household items, furniture, personal emergency response system, grab bars or other assistive devices, as well as limited transportation services during the transition or diversion process. Project Out links the consumer to community services and long-term care programs that may provide the on-going support needed for consumers to live independently.
- To be considered for Project Out services, a consumer must be a Wyoming resident, at least 18 years of age, and Medicaid eligible. During the transition or diversion process Medicaid eligibility must be determined. Until Medicaid eligible, state dollars fund the assistance.
- During SFY 2011, Project Out completed 36 transitions and 97 diversions, using both Medicaid and State funding. Wyoming defines a diversion as a person at risk of needing nursing facility care being able to remain in the community or a person who has been in a nursing facility for three months or less being able to return to the community to live. Wyoming defines a transition as a person currently residing in a nursing facility or long-term care institution for a minimum of three months. Identifying nursing home residents who want to return to the community through Minimum Data Set (MDS) collected by the nursing homes and increased education and outreach have resulted in consumers being educated earlier about their long-term care options. Remaining in the community or returning earlier to the community is generally more desirable for the consumer, and is the least costly for the State.
- Project Out is a fee-for-service program, providing services for 86 Medicaid eligible recipients, with expenditures totaling $68,763 in SFY 2011. The average amount spent per recipient during this period was $800.
- Each Project Out recipient collaborates with a Project Out case manager, his or her healthcare provider and/or discharge planner to create a transition or diversion plan, which includes those services and supports that are necessary to facilitate independent living.
- Project Out will continue to strive to increase awareness of the program within every Wyoming community. As more healthcare providers, discharge planners, and families become aware of the services available through Project Out, the number of consumers helped by the program should continue to increase.

Methodology and Data Sources

- The following provides a description of the data sources and the calculations that were used to determine the annual expenditure data included in this Report.
- For all services, annual expenditure data for SFYs 2008 through 2011 was identified by taxonomy using paid claims data from Medicaid's claims processing system. Prior SFY data represented in this Report do not match the data in prior SFY Annual Reports because the data criteria has changed and are re-extracted for this Report to be consistent for comparison purposes.
- We extracted data by provider taxonomy for four subpopulations:
    - Medicaid, including Medicaid-funded Foster Care
    - Medicaid-funded Foster Care
    - State-only funded Foster Care
    - Dual Eligible Individuals including crossover claims and Medicaid-only funded services
- For all data extracts, we have excluded third-party payments, co-payments and disproportionate share hospital payments as well as history only adjustments. Data extracts do not include expenditures for premium or cost-sharing assistance for Medicare eligible individuals.
- For expenditure data, we extracted claims data for original claims that were never voided/adjusted, original claims that were voided/adjusted, void/adjustment re-adjusted claims, and final adjustment claims. We included all Medicaid program codes from the Wyoming Eligibility Program Groups, Chart A: Medicaid, version 14, as well as N99 (Long-term care screening), S97 (CASII screening) and ZZZ (gross adjustments). The N99, S97 and ZZZ program codes are included in the expenditure data as these expenditures are Medicaid expenditures.
- For recipient data, we extracted claims data for original claims that were never voided/adjusted and final adjustment claims. We included all Medicaid program codes from the Wyoming Eligibility Program Groups, Chart A: Medicaid, version 14, but excluded N99 (Long-term care screening), S97 (CASII screening) and ZZZ (gross adjustments). The N99, S97 and ZZZ program codes are excluded from the eligible and recipient data as these individuals may not be Medicaid eligible.
- For some service areas, additional data or calculations were necessary. For inpatient and outpatient services, we used detailed paid claims expenditure data paid in SFY 2011, hospital Medicare cost report data and Medicaid's summary of SFY 2010 federal qualified rate adjustment (QRA) payments.[103]
- Eligibility criteria used to define our subpopulations follows in this section.
- The rest of this Appendix describes the following:
    - Eligibility
    - Additional data and calculations
    - Calculations of recipients and expenditures
- Exhibit 1 at the end of this section details the data parameters used to extract data for each service area included in this Report.

[103] To accurately represent payments received by hospitals during SFY 2011, we added the Federal Share of QRA payments calculated using SFY 2010 paid claims data to the SFY 2011 inpatient and outpatient hospital data.

APPENDIX A: METHODOLOGY AND DATA SOURCES

Eligibility

- There are four major categories of eligibility for Medicaid, which are described in detail in Section 2. We determined the number of eligible individuals for each of the four categories. We excluded program codes N99 (Long-term care screening), S97 (CASII screening) and ZZZ (gross adjustments) as well as all non- Medicaid program codes.
- We counted an individual as eligible if he or she was eligible at any point in time during the SFY.
- For the dual eligible data, the reports include several queries to identify the appropriate population and extract data for each service area separately. The first query identified all individuals who are eligible for Medicare, which, for non-pharmacy claims, required looking back 13 months prior to the beginning of the SFY to allow for a lag in submission of claims.[104] The next query matched this data to Medicaid eligibility data. This data represents the population of dually eligible individuals. From there we extracted recipient and expenditures data by service area for this subpopulation as indicated in Exhibit 1 at the end of this section.
- To exclude or include appropriate program groups in our Medicaid and foster care data extracts, we used the Wyoming Eligibility Program Groups, Chart A: Medicaid, version 14.

Program Codes

- To determine Medicaid data, we included Medicaid eligibility program codes on the claim header level.
- To determine Medicaid-funded and State-only funded Foster Care data, we used program codes specific to foster care.

Table 1: Medicaid Program Codes Included in the Analysis

Program Code Description	Program Code
Temp Assist Needy Family Ch	A02
Med Requirements Diff Child	A04
AFDC Medicaid	A50
2nd-6mos. Trans Mcaid Child	A54
Alien: 245 (IRCA) Child	A56
Baby <1 Yr, Mother SSI Elig	A57
Retro Medicaid-"Pr" Child	A59
Lost Mcaid, Increase Cs Child	A60
Institutional (AF-IV-E)	A61
Retro Medicaid-"Rm" Child	A62
Refugee Child	A63
Alien: 210 (IRCA) Child	A64
AFDC-Up Unemployed Parent Ch	A65
Post AFDC Mcaid 12mo Child	A67
16+ Not In School AF HH	A87
Continuous SSI/Iph <19	S62

[104] The pharmacy service area does not have this lag in claim submission because pharmacy claims are billed in real time.

APPENDIX A: METHODOLOGY AND DATA SOURCES

Program Code Description	Program Code
IV-E Foster Care	A51
IV-E Adoption	A52
Regular T-19 Foster Care	A85
Regular T-19 Subs. Adoption	A86
Foster Care Emancipated	A88
Foster Child Age 0-6	A97
Foster Child Age 6-13	A98
Continuous Foster Care <19	S63
Baby <1yr-5 (0-5)	A55
Children 6-18yr AFDC Income (6-18)	A58
Newborn Baby	A53
Pregnant Women - Child	A71
Pregnant Women - Adult	A72
Qual Preg Woman - Adult	A73
Qual Preg Woman - Child	A74
Presumptive Eligibility	A19
Temp Assist Needy Family Ad	A01
Med Requirements Diff Adult	A03
Post AFDC Mcaid 12mo Adult	A68
2nd-6mos. Trans Mcaid Adult	A69
AFDC Medicaid - Adult	A70
Institutional (AFDC) Adult	A75
Lost AFDC, Increase Cs Adult	A76
AFDC-Up Unemployed Parent Ad	A77
Retro Medicaid-"Pr" Adult	A78
Retro Medicaid-"Rm" Adult	A79
Refugee Adult	A80
Alien: 245 (IRCA) Adult	A82
Alien: 210 (IRCA) Adult	A83
Breast And Cervical Adult	B03
Breast And Cervical Child	B04
Tb-Infected Aged	S52
Tb-Infected Disabled	S53
Family Planning Waiver	A20
SSI Disabled Child	S09
Passalong Pickle Aged	S16
Passalong Pickle Disabled	S38
Widow/Widowers-"WW" Med Sub	S42
Qualified Working Disabled	S43
Eligible For SSI - Aged	S12
Blind, Receives Asst	S20

APPENDIX A: METHODOLOGY AND DATA SOURCES

Program Code Description	Program Code
Blind, Medicaid Only	S21
Eligible For SSI - Disabled	S31
Disabled Adult/Child DAC	S36
Goldberg-Kelly	S37
1619 Disabled	S39
Aptd Essent. Person Med Only	S40
Zebley Individual Adult	S48
Zebley Individual Child	S49
Widow/Widowers-"WS" Med Sub	S92
Pseudo SSI Aged	S98
Pseudo SSI Disabled	S99
Hospice-300% Aged	S50
Hospice-300% Disabled	S51
Institutional (Hosp) Aged	S14
Hospital-300% Cap Aged	S15
Institutional (Hosp) Disabled	S34
Hospital-300% Cap Disabled	S35
SSI Aged ICF-MR	S03
300% Aged ICF-MR	S04
SSI Disabled ICF-MR	S05
300% Disabled ICF-MR	S06
Inpatient Psych 65 And Over	S13
Nursing Facility Blend Aged	S01
Nursing Facility Blend Disabled	S02
Nursing Home-SSI Only Aged	S10
Nursing Home-300% Cap Aged	S11
Retro Medicaid-"Pr" Aged	S17
Retro Medicaid-"Rm" Aged	S18
Retro Medicaid-"Pr" Disabled	S30
Nursing Home-SSI Only Disabled	S32
Nursing Home-300% Cap Disabled	S33
No Nursing Facility/HCBS Aged	S54
No Nursing Facility/HCBS Dsab	S55
Retro Medicaid-"Rm" Disabled	S90
ABI Waiver - SSI Disabled	B01
ABI Waiver - 300% Cap Disabled	B02
ABI Waiver - EID	S60
ALF Waiver - SSI Disabled	R01
ALF Waiver - 300% Cap Disabled	R02
ALF Waiver - SSI Aged	R03
ALF Waiver - 300% Cap Aged	R04

APPENDIX A: METHODOLOGY AND DATA SOURCES

Program Code Description	Program Code
CMHW Waiver-SSI Only	S95
CMHW Waiver-300% Cap Child	S96
Continuous CMHW <19	S65
DD Waiver-SSI Only Aged	S22
DD Waiver-300% Cap Aged	S23
DD Waiver-SSI Only Disabled	S44
DD Waiver-300% Cap Disabled	S45
DD Waiver-EID Adult	S59
DD Waiver-EID Child	S58
DD Waiver-SSI Only Child	S93
DD Waiver-300% Cap Child	S94
Continuous DD Waiver <19	S64
LTC Waiver-SSI Only Aged	S24
LTC Waiver-300% Cap Aged	S25
LTC Waiver-SSI Only Disabled	S46
LTC Waiver-300% Cap Disabled	S47
Employed Disabled Indiv Adult	S56
Employed Disabled Indiv Child	S57
Continuous EID <19	S61
Qual. Mcare Bene (QMB)-Aged	Q17
Qual. Mcare Bene (QMB)-Disabled	Q41
Part B-100% Fed Aged	Q94
Part B-100% Fed Disabled	Q95
Special QMB (SLIMB) Aged	Q96
Special QMB (SLIMB) Disabled	Q97
Part B-Partial AMB Aged	Q98
Part B-Partial AMB Disabled	Q99
Alien: Emergency Svcs-Child	A81
Alien: Emergency Svcs-Adult	A84

Table 2: Foster Care Program Codes

Program Code Description	Program Code
Medicaid Foster Care	A51
Medicaid Foster Care	A52
Medicaid Foster Care	A85
Medicaid Foster Care	A86
Medicaid Foster Care	A88
Medicaid Foster Care	A97
Medicaid Foster Care	A98
Medicaid Foster Care	S63
State Funded – Pending Foster Care (Temporary for up to 60 days while eligibility is established)	A95
State Funded – Basic Foster Care (Child verified to not be Medicaid eligible)	A96
State Funded – Institutional Foster Care (Child in Public Institution, not eligible for Medicaid)	A99

Additional Data or Calculations

- For certain categories of services, it was necessary to make adjustments to data to correctly represent expenditures and individuals eligible for and receiving Medicaid services, as follows.

Ambulance

- We allocated expenditures and recipients between ground and air services based on the procedure code associated with each claim line. Most procedure codes apply only to either ground or air service, but procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 include both air and ground expenditures.
- To allocate expenditures and recipients to air ambulance services for these six procedure codes, we:
    - Calculated the total expenditures for ground-only procedure codes and the total expenditures for air-only procedure codes.
    - Calculated the percentage that air-only expenditures and air-only recipients comprise of all air-only and ground-only expenditures and recipients, respectively.
    - Multiplied total expenditures for procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 by the air-only expenditure percentage and added the result to the air-only ambulance expenditures.
    - Multiplied total recipients for procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 by the air-only recipient percentage and added the result to the air-only ambulance recipients.
- To allocate expenditures and recipients to ground ambulance services for these six procedure codes, we:
    - Calculated the total expenditures for ground-only procedure codes and the total expenditures for air-only procedure codes.

- Calculated the percentage that ground-only expenditures and ground-only recipients comprise of all air-only and ground-only expenditures and recipients, respectively.
- Multiplied total expenditures for procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 by the ground-only expenditure percentage and added the result to the ground -only ambulance expenditures.
- Multiplied total recipients for procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 by the ground-only recipient percentage and added the result to the ground-only ambulance recipients.

- This allocation approach may result in an overstatement of recipients for air-only and ground-only ambulance recipients as it is possible for an individual to fall into more than one group, e.g., an individual may receive air-only services and a service that includes both air and ground services within the same SFY.

Calculations for Expenditure and Recipient Figures

- Expenditures per recipient – Equal to the total expenditures for each fiscal year divided by the number of unique recipients for each fiscal year. We determined the number of unique recipients by counting the number of unique recipients who received services in each SFY. This distinct count provides an unduplicated count.
- Percentage change in total expenditures – Represents the increase or decrease in total expenditures for each year based on the percent change of total expenditures from one SFY to the next.
- Percentage change in number of recipients – Represents the increase or decrease in unique recipients for each year based on the percent change of unique recipients from one SFY to the next. We determined the number of unique recipients by counting the number of unique recipients who received services in each SFY. This distinct count provides an unduplicated count.
- Percentage change in expenditures per recipient – Represents the increase or decrease in expenditures per recipient for each year based on the percent change of expenditures per recipient from one SFY to the next.

APPENDIX A: METHODOLOGY AND DATA SOURCES

Exhibit 1: Data Parameters

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Ambulance (Total)	341600000X: Ambulance	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Ambulance (Air)	341600000X: Ambulance Procedure Codes: • A0030, A0430, A0431, A0435, A0436; • A0382, A0398, A0422, A0433, A0434 and A0998[105]	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Medical
Ambulance (Ground)	341600000X: Ambulance Procedure Codes: • A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428 and A0429; • A0382, A0398, A0422, A0433, A0434 and A0998	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Medical
ASC	261QA1903X: Ambulatory Surgery Center	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid[106]

[105] These procedure codes apply to both air and ground ambulance services. We split the expenditures for these procedure codes among air and ground ambulance services by 1) first determining the percent of ambulance expenditures, without expenditures for these procedure codes, that the State spent on air versus ground services and then 2) applying these percentages to the total expenditures for these procedure codes.

[106] To get the necessary level of detail, we used the Claims > Medical Path in Cognos for the data extract showing the ASC groupings.

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Behavioral Health (BH Providers)	101Y00000X: Professional Counselor; Certified Mental Health Worker 101YA0400X: Addictions Therapist/Practitioner 101YP2500X: Professional Counselor 103G00000X: Neuropsychologist 103TC0700X: Clinical Psychologist 1041C0700X: Social Worker 106H00000X: Marriage and Family Therapist 163W00000X: RN 164W00000X: LPN 171M00000X: Case Worker 172V00000X: Community Health Worker; Peer Specialist; Certified Addictions Practitioner Assistant 2084P0800X: Psychiatrist 261QM0801X: Mental Health – Including Community Mental Health Center 261QR0405X: Rehabilitation, Substance Use Disorder 364SP0808X: NP, APN Psychiatric/Mental Health	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Behavioral Health (Non-BH Providers Providing BH Services)	Exclude 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 2084P0800X, 261QM0801X, 261QR0405X, 364SP0808X (Behavioral Health) Procedure Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90820, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 95816, 95957, 96100, 96101, 96102, 96103, 96105, 96110, 96111, 96116, 96117, 96118, 96119, 96120, 96125, G9012, H0001, H0005, H0006, H0031, H0034, H0047, H2010, H2014, H2015, H2017, H2019, H2021, T1007, T1012, T1017, T2011	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Medical

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
CORF	261QR0401X: Rehabilitation, Comprehensive Outpatient Rehabilitation	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Dental	122300000X: Dentist 1223D0001X: Dental Public Health 1223E0200X: Endodontics 1223G0001X: General Practice 1223P0221X: Pedodontics 1223P0300X: Periodontics 1223S0112X: Surgery, Oral and Maxillofacial 1223X0400X: Orthodontics	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid[107]
DMEPOS (Total)	332B00000X: DME 332S00000X: Hearing Aid Equipment 335E00000X: POS	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
DMEPOS (DME)	332B00000X: DME 332S00000X: Hearing Aid Equipment	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
DMEPOS (POS)	335E00000X: POS	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

[107] To get the necessary level of detail, we used the Claims > Dental Path in Cognos for the data extracts showing the top five dental procedure codes.

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
ESRD	261QE0700X: End-Stage Renal Disease	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
FQHC	261QF0400X: Federally Qualified Health Center	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Home Health	251E00000X: Home Health	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Hospice Care	251G00000X: Hospice Care, Community Based	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Hospital (Total)	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283Q00000X: Psychiatric Hospital 283X00000X: Rehabilitation Hospital	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Hospital (Inpatient)	282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283Q00000X: Psychiatric Hospital 283X00000X: Rehabilitation Hospital	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	I, X	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Hospital (Outpatient)	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283X00000X: Rehabilitation Hospital	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	O, V	> Claims > All Paid
Interpreter Services	171R00000X: Interpreter	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Laboratory	291U00000X: Clinical Medical Laboratory	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Nursing Facilities	275N00000X: Medicare Defined Swing Bed 314000000X: Skilled Nursing Facility	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Physicians and Other Practitioners (Total)	207W00000X: Ophthalmologist, excluding diagnosis V72.0 (routine vision services) All taxonomies starting with '20' (except 2084P0800X: psychiatrists) 363A00000X: Physician Assistant 225X00000X: Occupational Therapist 225100000X: Physical Therapist 213E00000X: Podiatrist 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X: Nurse Practitioner 367A000000X: Nurse Midwife 367500000X: Nurse Anesthetist 231H00000X: Audiologist 235Z00000X: Speech-language Pathologist	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Physicians and Other Practitioners (Physicians)	207W00000X: Ophthalmologist, excluding diagnosis V72.0 (routine vision services) All taxonomies starting with '20' (except 2084P0800X: psychiatrists) 363A00000X: Physician Assistant	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Physicians and Other Practitioners (Other Practitioners)	225X00000X: Occupational Therapist 225100000X: Physical Therapist 213E00000X: Podiatrist 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X: Nurse Practitioner 367A000000X: Nurse Midwife 367500000X: Nurse Anesthetist 231H00000X: Audiologist 235Z00000X: Speech-language Pathologist	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Pharmacy	333600000X: Pharmacy	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
PRTF	323P00000X: Psychiatric Residential Treatment Facility 322D00000X: Residential Treatment Facility, Emotionally Disturbed Children	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	323P00000X – All 322D00000X – I	> Claims > All Paid
Radiology (Mobile)	261QR0208X: Mobile Radiology	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Radiology (Physician)	Exclude 261QR0208X (Mobile Radiology) Procedure Codes: 70000–79999	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Medical
RHC	261QR1300X: Rural Health Clinic	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Vision	152W00000X: Optometrist 156FX1800X: Optician 207W00000X: Ophthalmologist, limited to diagnosis V72.0 (routine vision services) only	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Waiver (HCBS ABI) **(Total Waiver and Non-Waiver)**	All	B01, B02, S60	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Waiver (HCBS ABI) **(Waiver Only)**	251C00000X: Day Training, DD	B01, B02, S60	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS ABI) **(Non-Waiver Only)**	Exclude 251C00000X (Day Training, DD)	B01, B02, S60	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (HCBS Adult DD) **(Total Waiver and Non-Waiver)**	All	S22, S23, S44, S45 , S59	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Waiver (HCBS Adult DD) **(Waiver Only)**	251C00000X: Day Training, DD	S22, S23, S44, S45 , S59	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS Adult DD) **(Non-Waiver Only)**	Exclude 251C00000X (Day Training, DD)	S22, S23, S44, S45 , S59	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (HCBS Child DD) **(Total Waiver and Non-Waiver)**	All	S58, S93, S94, S64	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Waiver (HCBS Child DD) **(Waiver Only)**	251C00000X: Day Training, DD	S58, S93, S94, S64	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS Child DD) **(Non-Waiver Only)**	Exclude 251C00000X (Day Training, DD)	S58, S93, S94, S64	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (HCBS Children's Mental Health) **(Total Waiver and Non-Waiver)**	All	S95, S96, S65	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Waiver (HCBS Children's Mental Health) **(Waiver Only)**	251C00000X: Day Training, DD	S95, S96, S65	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS Children's Mental Health) **(Non-Waiver Only)**	Exclude 251C00000X (Day Training, DD)	S95, S96, S65	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (HCBS ALF) **(Total Waiver and Non-Waiver)**	All	R01, R02, R03, R04	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Waiver (HCBS ALF) **(Waiver Only)**	251B00000X: Case Management	R01, R02, R03, R04	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS ALF) **(Non-Waiver Only)**	Exclude 251B00000X (Case Management)	R01, R02, R03, R04	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (HCBS LTC) **(Total Waiver and Non-Waiver)**	All	S24, S25, S46, S47	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid
Waiver (HCBS LTC) **(Waiver Only)**	251B00000X: Case Management	S24, S25, S46, S47	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	W, G	> Claims > All Paid
Waiver (HCBS LTC) **(Non-Waiver Only)**	Exclude 251B00000X (Case Management)	S24, S25, S46, S47	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	Exclude W	> Claims > All Paid
Waiver (Pregnant by Choice)	All	A20	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	All	> Claims > All Paid

APPENDIX A: METHODOLOGY AND DATA SOURCES

Service Area	Provider Taxonomy / Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type Code in Path	Cognos Path
Crossover Claims	All	Expenditures – Chart A including N99, S97, ZZZ Recipient Count – Chart A excluding N99, S97, ZZZ	Expenditures – 0, 1, 2, F Recipient Count – 0, F	Exclude: 1, 6, 7, G, H, I, J, K, L (exclude history)	B, V, X	> Claims > All Paid

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Ambulance	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. Fee schedule developed in 1989 based on comparison to Medicare's fees. • Fixed fee schedule amount for transport. • Mileage and disposable supplies billed separately. • Separate fee schedules for basic life support (ground); advanced life support (ground); additional advanced life support (ground) and air ambulance. • Rates for basic life support and advanced life support (ground) updated based on comparison to rates of surrounding states (effective July 1, 2004) • All air ambulance codes updated based on comparison to rates of surrounding states (effective January 1, 2006). • In SFY 2006, mileage for air ambulance increased to $11.20 per mile.	No change	• Fees adjusted to be based on 90 percent of Medicare's 2007 ambulance rates. • Ground mileage increased 125 percent from $2.50 to $5.63 per mile. • Mileage for fixed wing air ambulance decreased to $10.12 per mile, but the base rate increased 325 percent from $776.99 to $3,303.63. • Mileage for rotary wing air ambulance increased to $26.95 per mile, and Base rates increased 627 percent from $528.34 to $3,840.96.	• No change	Fees adjusted to 75 percent of Medicare's 2008 ambulance rates.	No change
Ambulatory Surgery Centers (ASCs)	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Fee schedule established in 1989 using Medicare's rates and subsequently updated to reflect October 1, 1992 Medicare national rates.	• Fees increased to 90 percent of Medicare's 2007 ASC rates (effective January 1, 2007).	• Ninth ASC payment Group Y added for miscellaneous services that are not paid through the other eight ASC payment groups. • Group Y codes paid at 70 percent of charges.	• New codes billed by ASCs not included in other 8 groups paid at 70 percent of charges.	No change	No change
Behavioral Health	• Lower of the Medicaid fee schedule or the provider's usual and customary charges.	No change	• Legislated and funded rate increase of 24	No change	• CPT Level I codes reduced to 90% of Medicare (effective	No change

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	• Fee schedule established by the Mental Health and Substance Abuse Services Division. • Last update was in July 2002.		percent from $70 per hour to $87 per hour. • State portion of the increase effective July 1, 2007. Federal match effective September, 2007.		November 1, 2009).	
Comprehensive Outpatient Facility (CORF)	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Last update was in 1994.	No change	• No change.	Payment methodology changed to a HCPCS fee schedule.	No change	No change
Dental	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • In July 2000, dental fees updated to: ➢ Top 20 procedures: Higher of the fee schedule or 90 percent of the average charge in SFY 1999. • All other procedures: 85 percent of the average charge in SFY 1999. • Legislated and funded fee increase to the 75th percentile of usual and customary charges (effective September 2004).	• $1,891,700 in general funds and $2,108,800 in federal funds to provide optional dental services for adults (effective July 1, 2006).	No change	No change	No change	No change
Durable Medical Equipment, Prosthetics and Orthotics	• Lower of the Medicaid fee schedule, or the provider's usual and customary charges for each HCPCS code. Medicaid uses Medicare's fee schedule, which is updated annually for inflation based on the consumer price index. For procedure codes not on Medicare's list, Medicaid considers other states' rates. • Certain DME, e.g., customized wheelchairs, is manually priced	• Fees updated annually per Medicare's inflation increases. • Reviewed rates for codes that have not been updated since SFY 2003 (i.e., procedure codes not included in the Medicare fee	• Fees updated to 90 percent of Medicare. (effective February 1, 2008)	• Fees updated to 90 percent of Medicare (effective January 1, 2009).	No change	No change

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	based on the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling. • In SFY 2003, updated fee schedule for certain services that are manually priced. • In SFYs 2004-2006, fees updated annually per Medicare's inflation increases. • For mileage related to DME deliveries, increase to $.40 per mile for deliveries over 50 miles round trip (effective October 2005).	schedule).				
End Stage Renal Disease Services	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Last update was in 1994.	No change	No change	• Fees paid at 70 percent of billed charges for dialysis services and the lower of the Medicaid fee schedule or the provider's usual and customary charges for other ESRD services (effective September 1, 2008).	No change	Fees paid at 24 percent of billed charges for dialysis services and the lower of the Medicaid fee schedule or the provider's usual and customary charges for other ESRD services (effective September 1, 2010)
Federally Qualified Health Centers	• Prior to January 1, 2001, Medicaid reimbursed FQHCs using Medicare's rates. • Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000. ➢ Based on 100 percent of a facility's average costs during SFYs 1999 and 2000. ➢ Rates updated annually for inflation based on the Medicare Economic Index	• Updated based on MEI (2.1 percent).	• Updated based on MEI (1.8 percent).	• Updated based on MEI (1.6 percent).	• Updated based on MEI (1.2 percent).	• Updated based on MEI (0.4 percent).

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	(MEI).					
Home Health	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Fee schedule established in 1989, based on Medicare's rates.	• Legislated and funded per-visit rate increase of 30 percent from $64 per visit to $84 per visit for skilled nursing, physical therapy, speech therapy, occupational therapy home health aide and medical social workers (effective July 1, 2006).	No change	No change	No change	No change
Hospice	• Fees based on Medicare rates. Medicare pays a per-diem rate based on level of care and updates fees annually based on inflation. • For nursing facilities that provide hospice services, payment is 95 percent of the facility's Medicaid per diem rate and is made to the hospice in lieu of the nursing facility reimbursement. • Previous to 2004, lower of the current Medicaid fee schedule or the provider's usual and customary charges. • SFYs 2005-2006, fees updated per Medicare's inflation increases.	• Fees updated per Medicare's inflation increases.	• Fees updated per Medicare's inflation increases.	• Fees updated per Medicare's inflation increases.	• Fees updated per Medicare's inflation increases.	• Fees updated per Medicare's inflation increases.
Inpatient Hospital	• Prospective level of care (LOC) rate per discharge implemented on July 1, 1994 and rebased in 1998. Services paid outside of the LOC system are: ➢ Extended psychiatric and specialty rehabilitation services (as opposed to general rehabilitative	• LOC rates updated for inflation (3.4 percent) • No change for QRA	• LOC rates updated for inflation (3.2 percent) • No change for QRA	• LOC rates updated for inflation (3.1 percent) • No change for QRA	• Rebased the LOC system using more recent cost and claims data to better categorize services and to calculate new payment rates. New rates	• No change to LOC rates • No change for QRA

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	services) paid using a negotiated per diem fee schedule. ➢ Transplant services are paid at 55 percent of billed charges. • Hospitals that serve a disproportionate share of low-income patients receive disproportionate share hospital (DSH) payments. • Prior to May 2001 extended psychiatric, specialty rehabilitation, transplant, neonatal intensive care and maternal fetal monitoring services paid through selective contracting under a federal waiver. • LOC rates updated annually for inflation using the Medicare inpatient prospective payment (PPS) inflation rates. • Qualified Rate Adjustment (QRA) program implemented on July 4, 2004 to provide supplemental payments to non-state governmental hospital.				implemented September 1, 2009. • Legislated approved budget reduction of $5.8 million over two years based on Governor's recommendations. • Based on a budget footnote, the Governor's office authorized on increase to The Children's Hospital rates after the required reductions, resulting in an increase of $1 million over a two year period. • Based on meetings with Senior Management of Wyoming Department of Health and Wyoming Behavioral Institute, direction was given to increase Wyoming Behavioral Institute's rates after the required reductions, resulting in an increase of $2 million over a two year period. • Between the budget footnote and the Senior Management meetings above, the overall reduction to inpatient hospital	

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
					rates is expected to reflect $2.8 million instead of $5.8 million. • No change for QRA.	
Interpreter Services	• Lower of Medicaid fee schedule or the provider's usual and customary charges.	No change	No change	No change	No change	No change
Laboratory	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Fees updated annually according to Medicare updates. • SFY 2005, Fee schedule updated for all codes.	• Fees updated annually according to Medicare updates.	• Fees updated to 90 percent of Medicare's fee schedule. • Twelve laboratory procedure codes updated to 80 percent of SFY 2007 average billed charges.	• Fees updated to 90 percent of Medicare's fee schedule.	No change	No change
Nursing Facility	• Prospective per diem rate with rate components for capital cost, operational cost and direct care costs. • Rates updated annually based on analysis of Medicaid cost reports. • SFY 2005, rates updated based on analysis of Medicaid cost reports. • SFY 2006, rebased rates using 2004 cost data. • SFY 2006, WY Legislated and funded increase of $4.2 million.	• Rates updated based on analysis of Medicaid cost reports.	• Rates updated based on analysis of Medicaid cost reports.	• Rates updated based on analysis of Medicaid cost reports.	• Rates updated based on analysis of Medicaid cost reports.	• No change due to rate freeze approved by legislation session spring of 2010. • Provider Tax added effective 04/01/11 after WY Legislative and federal approval. First payments were not made until SFY 2012.
Outpatient Hospital	• Fee schedule amounts updated for certain services, such as specified laboratory codes,	• Increased conversion factors so that the	• Increased conversion factors so that the	• Increased conversion factors so that the	• No change to conversion factors (Calendar Year	• Adjusted conversion factors (Calendar Year

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	based on Medicare's updated professional services fee schedule. • Bundled, prospective fee schedule approach for surgical outpatient hospital services (July 1, 1994); each surgical procedure code is assigned to one of 16 bundled payment groups modeled after Medicare's Ambulatory Surgery Center groupings. • Radiology and laboratory services paid according to procedure codes. • Other "standalone" services paid the lower of charges and a revenue code-based fee schedule. • Critical access hospitals excluded from system on October 1, 2001, and paid 70 percent of billed charges. • Qualified Rate Adjustment (QRA) program implemented on July 4, 2004 to provide supplemental payments to non-state governmental hospital. • SFY 2005, fee schedule amounts updated for certain services, such as laboratory, when Medicare updated its professional services fee schedule. • SFY 2006, outpatient prospective payment system based on Medicare's Ambulatory Payment Classifications (APCs) system implemented (October 2005). APCs are used to pay for significant outpatient procedures, ancillary services and drugs. Certain services are excluded from the APC-based methodology and paid under	Calendar Year 2007 conversion factors equaled the same percentage of the Medicare conversion factors as they did when Medicaid initially implemented the system. • Conversion factors: General hospitals - $46.10; Critical access hospitals - $120.48; Children's hospitals - $105.11 (effective January 1, 2007). • No change for QRA	Calendar Year 2008 conversion factors equaled the same percentage of the Medicare conversion factors as they did when Medicaid initially implemented the system. Calendar Year 2008 conversion factors: General hospitals - $47.77; Critical access hospitals - $124.84; Children's hospitals - $108.92 (effective January 1, 2008). • No change for QRA	Calendar Year 2009 conversion factors equaled the same percentage of the Medicare conversion factors as they did when Medicaid initially implemented the system. • Conversion factors: General hospitals - $49.54; Critical access hospitals - $129.48; Children's hospitals - $112.96 (effective January 1, 2009). • No change for QRA	2010 conversion factors equal 2009 levels) • Conversion factors: General hospitals - $49.54; Critical access hospitals - $129.48; Children's hospitals - $112.96. • No change for QRA	2011 conversion factors). Conversion factors were kept budget neutral in the aggregate across all three factors. • Conversion factors: General hospitals - $48.65; Critical access hospitals - $129.22; Children's hospitals - $105.62. • No change for QRA

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	other Medicaid fee schedules. Services excluded from the APC-based methodology are paid the lower of the Medicaid fee schedule or the provider's usual and customary charges. • Initial conversion factors: General hospitals - $44.28; Critical access hospitals - $116.60; Children's hospitals - $101.75.					
Physicians/ Practitioners	• Fee schedule was established in July 1989. • Payments for anesthesiologists based on relative weights developed and published by McGraw-Hill. • Prior to SFY 2003, lower of the Medicaid physician fee schedule or the provider's usual and customary charges. • SFY 2003, lower of the Medicaid Resource-Based Relative Value System (RBRVS)-based fee schedule (effective July 1, 2002) or the provider's usual and customary charges. Fee schedule based on Medicare 2002 Relative Value Units (RVUs) and a conversion factor of $32.90. • SFY 2003, payments for anesthesiologists did not change. • SFY 2005, adopted Medicare 2004 RVUs (August 1, 2004). • SFY 2005, increased conversion factor by $3.30 to $36.20. • SFY 2005, WY Legislated and funded rate increase for selected obstetric and neonate services to 90 percent of usual and customary charges (effective	• Adopted Medicare 2006 RVUs (January 1, 2007). • Physician services fees updated (January 1, 2007). • Increased the conversion factor for anesthesiologists by $15.20 to $36.20 for selected obstetric codes (January 1, 2007).	No change	No change	• Adopted Medicare 2009 RVUs (effective August 1, 2009). • Updated the conversion factors for physician services (effective August 1, 2009). • Reimbursement budget reduced by $4.8 million.	No change

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	July 1, 2004). • SFY 2006, payments for anesthesiologists based on relative weights developed and published by the American Society of Anesthesiologists					
Prescription Drugs	• Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge (effective 2001). • EAC is the Average Wholesale Price (AWP) minus 11 percent. • Dispensing fee is $5.00 per prescription. • AWP is determined by pricing information supplied by pharmaceutical manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC). • Preferred drug list implemented in SFY 2004, which by late 2005 included nine drug groups. • SFY 2005, co-payments implemented as follows: $1.00 for generics, $2.00 for preferred drug list brand medications and $3.00 for other brand medications (recipients under age 21, nursing facility residents, pregnant women, family planning services, emergency services, and hospice services are exempt). • SFY 2006, Medicare voluntary prescription drug benefit implemented (January 1, 2006), providing prescription drug coverage to persons who are	No change	No change	Preferred Drug List expanded to 21 specific drug classes	Effective April 1, 2010, co-payments changed as follows: $1.00 for generics (multisource medications) and $3.00 for all brand-name medications (recipients under age 21, nursing facility residents, pregnant women, family planning services, emergency services, and hospice services are exempt) Preferred Drug List expanded to 32 specific drug classes.	Preferred Drug List expanded to 80 specific drug classes.

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	dually eligible for Medicare and Medicaid.					
PRTFs	• Negotiated rates with individual providers.	No change	No change	No change	Payment based on individual provider cost-based rates.	Payment based on individual provider cost-based rates.
Radiology	• Lower of the Medicaid Relative-Value Unit (RVU)–based fee schedule (implemented in 1990) or the provider's usual and customary charges. • Last conversion factor update was in 1994.	• Fees updated, but update did not apply to all radiology rates.	• Fees updated to 90 percent of Medicare's non-facility fully-implemented RVU rates.	• Fees updated to 90 percent of Medicare's non-facility fully-implemented RVU rates.	No change	No change
RHCs	• Prior to January 1, 2001, Medicaid reimbursed RHCs using Medicare's rates. • Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000. ➢ Based on 100 percent of a facility's average costs during SFYs 1999 and 2000. ➢ Rates updated annually for inflation based on the Medicare Economic Index (MEI).	• Updated based on MEI (2.1 percent).	• Updated based on MEI (1.8 percent).	• Updated based on MEI (1.6 percent).	• Updated based on MEI (1.2 percent).	• Updated based on MEI (0.4 percent).
Vision	• Fee schedule established in July 1989. • Lenses are billed by invoice. • Prior to SFY 2003, lower of the Medicaid physician fee schedule or the provider's usual and customary charges. • SFY 2003, reimbursement for optometrists and ophthalmologists is lower of the Medicaid RBRVS fee schedule or the provider's usual and	No change	No change	No change	No change	No change

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
	customary charges. • SFY 2006, frames allowable fee updated to $76.					
Waiver Services – Adult DD, Child DD and ABI Waivers	• Individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics. • Payment for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. • Consumers negotiate rates based on their budget amount. • SFY 2005, three percent rate increase for Adult direct professional wages.	• Rates updated for direct professional services only (effective July 1, 2006). • Seven percent rate increase for direct professional wages for the Adult, Child and ABI Waivers.	• Three percent rate increase for all services for the Adult, Child and ABI Waivers.	• New cost-based reimbursement methodology implemented on July 1, 2008.	Rates were reduced 10% due to budget reduction.	A 6% restoration of the SFY 2010 10% rate reduction (or 96% of the SFY 2009 rates) was implemented
Waiver Services – Children's Mental Health Waiver	Not applicable	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Procedure code-based rates developed based on rates for community mental health services and other comparable providers.	No change	No change	Rates were modified in the waiver renewal for all three waiver services. Rate changes were developed with cost neutral impact to program funding.	No change
Waiver Services - Long-Term Care and Assisted Living Facility Waivers	• Based on a fee schedule developed by the Developmental Disabilities Division and Aging Division. • Fees limited to a monthly or yearly cap per person, according to the established care plan.	• Legislated and funded rate increase for personal care attendant to $20 for the Long-Term Care Waiver. Self-directed services rates increased to	No change	No change	No change	No change

APPENDIX B: WYOMING MEDICAID RATE HISTORY

Service Area	SFY 2006 and Previous	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
		$12.				
Waiver Services - Pregnant by Choice Waiver	Not applicable	Not applicable	Not applicable	The fee schedule reflects the services rendered. .	No change	No change

Supplementary Tables and Charts

- This Appendix provides tables and charts reporting useful data related to Medicaid programs.

Demographics

- The Medicaid demographics section provides a summary of basic demographic information (e.g., age, race, gender) about recipients using Wyoming Medicaid services in SFY 2011.

Utilization and Expenditures

- The utilization and expenditures section outlines expenditures, recipients, expenditures per eligible and expenditures per recipient for SFY 2011. The utilization and expenditure chart displays service area recipient utilization and expenditures as a percentage of total utilization and expenditures. The purpose of this chart is to compare service areas to determine how utilization and expenditures are distributed in the Wyoming Medicaid system.

Eligibility

- The eligibility section summarizes Medicaid eligibility by category and lists the basic requirements for each, along with the associated Medicaid benefit levels, type of income and income resource limits.

Co-Payments

- A co-payment is a fixed amount of money paid by the Medicaid enrollee at the time of service. The co-payment section provides a summary of Medicaid co-payments, the types of services that require a co-payment and exceptions to the requirements for a co-payment.

Birth Report

- The birth report provides a summary of the number of births in Wyoming and the number of births paid by Medicaid from 1996 to 2010. We use this data to estimate the percentage of births paid by Medicaid in each year. This report is also used in the monitoring of the 1115 Pregnant by Choice Waiver, which began January 1, 2009.

Demographics

Table 1: SFY 2011 Medicaid Recipients by Age and Gender

Age Group	Gender			
	Male		Female	
	Count	%	Count	%
0-20 years	26,250	79	25,578	58
21-64 years	5,333	16	14,965	34
65+	1,526	5	3,645	8
Total	33,109	100	44,188	100

Table 2: SFY 2011 Medicaid Recipients by Age and Race

Age Group	Race							
	White		Black		American Indian/Alaskan Native		Other	
	Count	%	Count	%	Count	%	Count	%
0-20 years	37,807	64	1,188	76	1,701	73	11,132	75
21-64 years	16,296	28	340	22	548	24	3,114	21
65+	4,550	8	37	2	67	3	517	4
Total	58,653	100	1,565	100	2,316	100	14,763	100

APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Table 3: SFY 2011 Medicaid Eligible Individuals and Recipients by County

Category	Number of Eligible Individuals SFY 2011	Percentage of Total Eligible Individuals	Number of Recipients SFY 2011	Percentage of Total Recipients
Laramie	15,214	17	13,586	17
Natrona	13,196	15	11,501	14
Fremont	10,800	12	10,124	13
Sweetwater	6,078	7	5,284	7
Campbell	5,163	6	4,917	6
Park	4,596	5	4,045	5
Albany	4,495	5	3,813	5
Sheridan	4,086	5	3,646	5
Uinta	3,964	4	3,554	4
Lincoln	3,037	3	2,694	3
Carbon	2,699	3	2,370	3
Goshen	2,569	3	2,328	3
Converse	2,107	2	1,905	2
Big Horn	1,674	2	1,533	2
Washakie	1,515	2	1,362	2
Weston	1,456	2	1,204	2
Platte	1,432	2	1,308	2
Teton	1,278	1	1,079	1
Crook	1,168	1	1,011	1
Johnson	1,052	1	923	1
Hot Springs	896	1	867	1
Sublette	851	1	650	1
Niobrara	490	1	414	1
Other	15	<1	0	0
Total	89,831	100	80,118	100

Utilization and Expenditures

Table 1: Medicaid Service Area Expenditures, Recipients, Expenditures per Recipient and Expenditures per Eligible, SFY 2011 (Ranked by Total Expenditures in Each Service Area)

Service Area	Expenditures	Percent Change FY10 – FY11	Expenditures as a Percent of Total Expenditures	Expenditures per Eligible	Percent Change FY10 – FY11	Recipients	Percent Change FY10 – FY11	Expenditures per Recipient	Percent Change FY10 – FY11
Waiver Services[108]	$ 120,049,329	6	23	$ 1,726	5	4,493	1	26,719	5
Adult DD Waiver	81,369,215	7	16	1,170	7	1,355	1	60,051	6
Child DD Waiver	14,128,741	-2	3	203	-3	799	-1	17,683	-2
LTC Waiver	13,912,032	4	3	200	3	1,809	-1	7,690	4
ABI Waiver	6,963,271	12	1	100	11	177	-8	39,341	21
ALF Waiver	2,757,617	-10	1	40	-11	217	-8	12,708	-2
Children's Mental Health Waiver	918,455	134	< 1	13	133	136	77	6,753	33
Hospital[109]	114,357,604	1	22	1,644	-0	43,940	1	2,603	< 1
Inpatient[110]	84,557,214	-3	16	1,216	-4	11,745	-4	7,199	1
Outpatient[111]	29,691,724	13	6	427	12	41,348	1	718	12
Nursing Facilities[112]	73,180,333	-3	14	1,052	-4	2,460	-6	29,748	3
Physicians and Other Practitioners[113]	65,168,221	0	13	937	-1	65,060	2	1,002	-2

[108] There were 425 Pregnant by Choice Waiver recipients and expenditures of $106,300 in SFY 2011 that were excluded from this table because they were included in the expenditures for other service areas. See the Waiver Services section for more information.
[109] Total hospital expenditures include adjustments that could be either inpatient or outpatient.
[110] Excludes DSH and QRA.
[111] Excludes QRA.
[112] Excludes Provider Assessment.
[113] The physician data includes expenditures for behavioral health services provided by non-behavioral health professionals. See the Behavioral Health services section for more information.

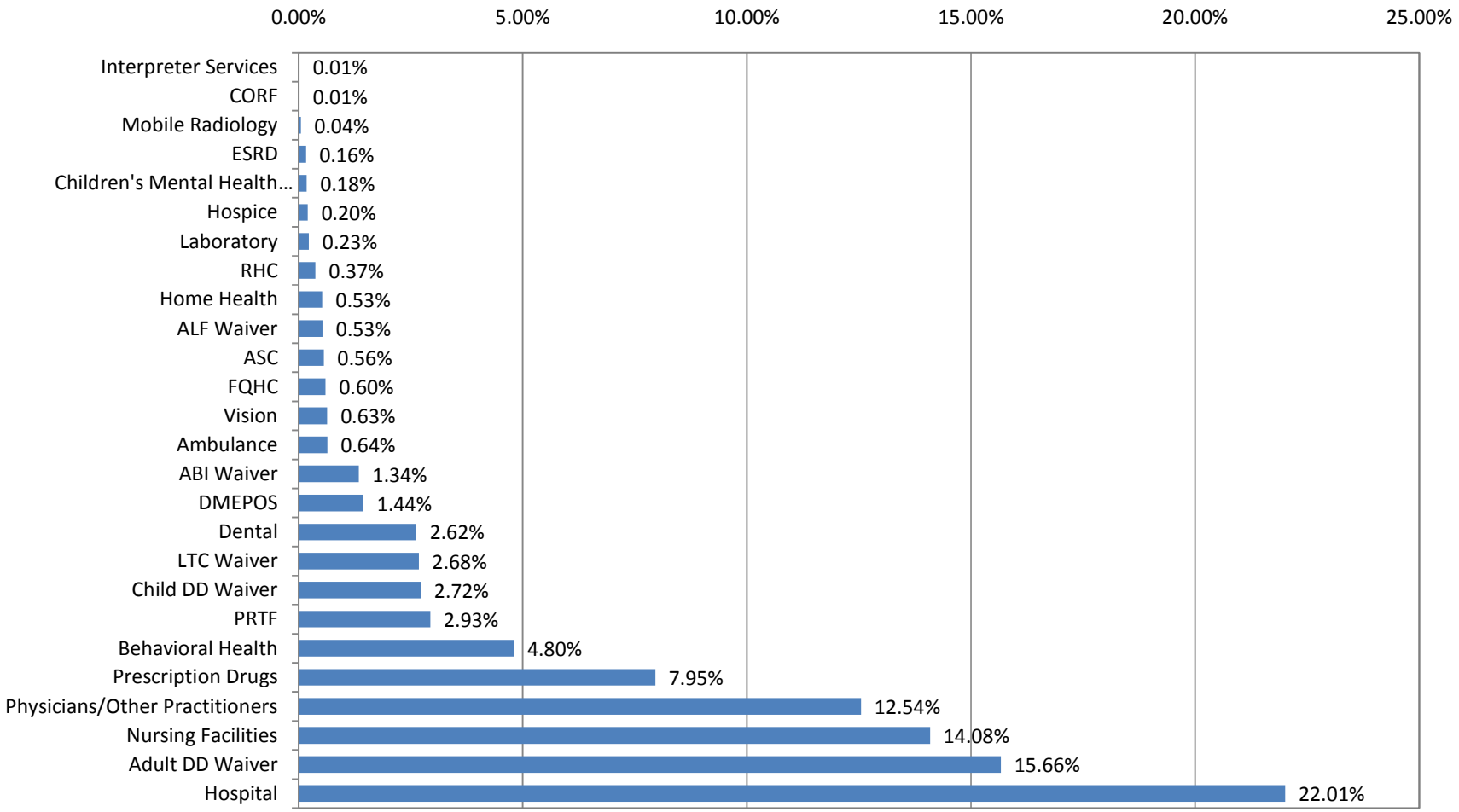
APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Service Area	Expenditures	Percent Change FY10 – FY11	Expenditures as a Percent of Total Expenditures	Expenditures per Eligible	Percent Change FY10 – FY11	Recipients	Percent Change FY10 – FY11	Expenditures per Recipient	Percent Change FY10 – FY11
Prescription Drugs	41,330,767	7	8	594	6	50,131	2	824	4
Behavioral Health[114]	24,927,506	9	5	358	8	10,529	7	2,368	1
PRTF	15,244,613	4	3	219	3	404	-8	37,734	13
Dental	13,616,583	6	3	196	5	28,293	7	481	-1
DMEPOS	7,505,683	14	1	108	13	7,526	1	997	12
Ambulance	3,303,240	-13	1	47	-14	3,659	9	903	-20
Vision	3,286,215	1	1	47	0	14,700	3	224	-1
FQHC	3,103,164	8	1	45	7	4,855	18	639	-8
ASC	2,912,791	-12	1	42	-13	3,161	3	921	-15
Home Health	2,732,905	41	1	39	40	623	6	4,387	33
RHC	1,940,640	13	< 1	28	13	5,539	19	350	-4
Laboratory	1,171,185	4	< 1	17	4	9,956	1	118	3
Hospice	1,036,887	-28	< 1	15	-28	150	2	6,913	-29
ESRD	835,621	-28	< 1	12	-29	86	4	9,717	-31
Mobile Radiology	217,463	-2	< 1	3	-3	557	10	390	-11
CORF	56,646	54	< 1	1	53	147	81	385	-15
Interpreter Services	54,259	13	< 1	1	13	420	9	129	4
Other Services[115]	23,572,623	-22	5	339	-22	14,412	14	1,636	-31

[114] Includes behavioral health services provided by behavioral health professionals.
[115] Other services comprise of services that were out of the criteria ranges.

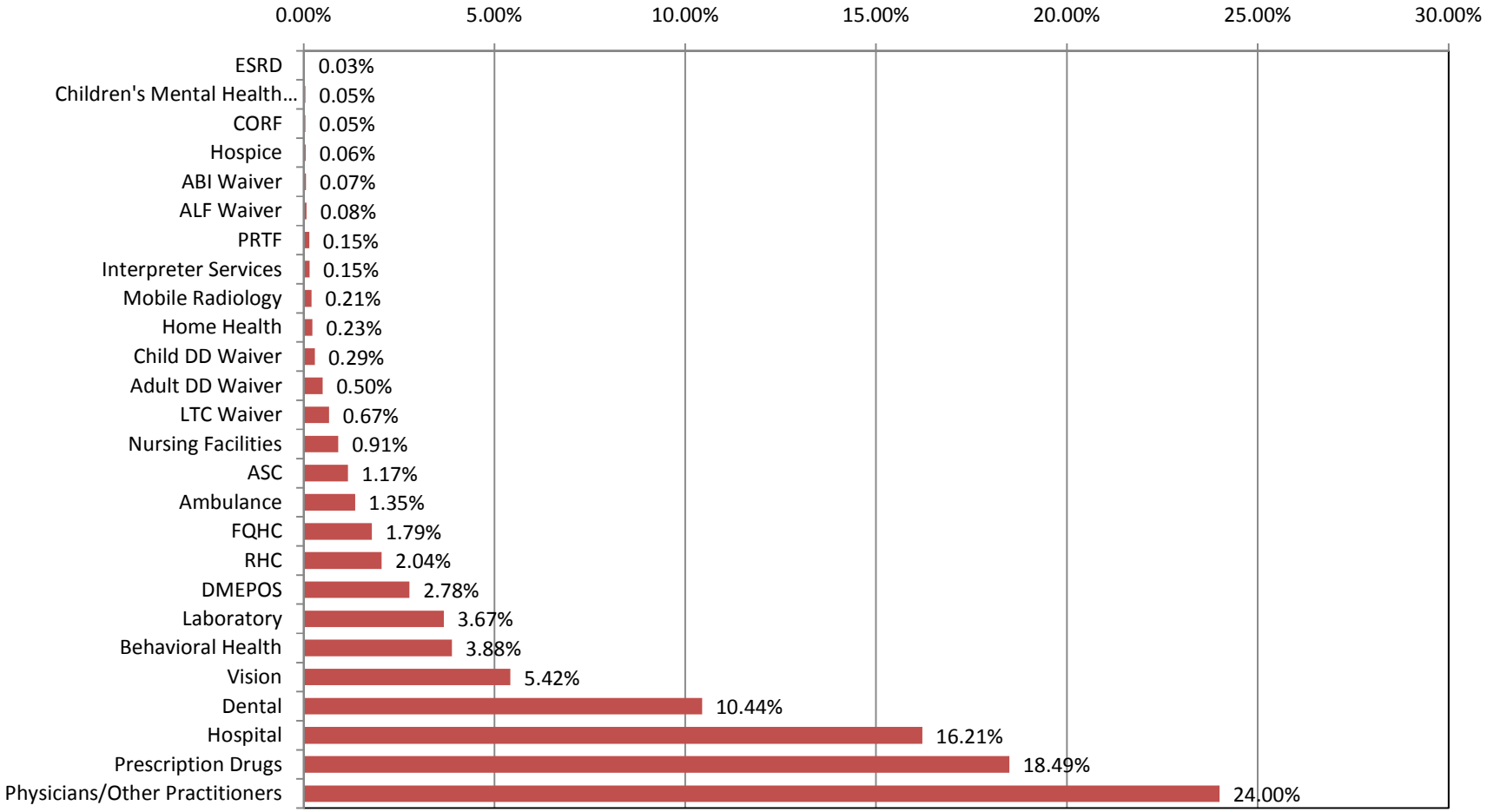
APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Table 2: Medicaid Service Area Expenditures as a Percentage of Total Expenditures, SFY 2011



APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Table 3: Medicaid Service Area Recipient Counts as a Percentage of Total Recipients, SFY 2011



Eligibility

- In Table 1, we summarize Medicaid eligibility by category and list the basic requirements for each, along with the type of income, income resource limits and the associated Medicaid benefit levels. Note that Table 1 does not list information for services provided through the Medicaid waivers. Section 4 provides more information on Medicaid's waiver programs.
- There are numerous mandatory and optional Medicaid eligibility categories defined by federal law. For ease of presentation, we present an overview of these categories in Table 1; each row on Table 1 might actually represent several different federal eligibility categories.
    - *For example:*
        - *Table 1 lists the pregnant women eligibility category and indicates that Wyoming covers pregnant Wyoming citizens less than or equal to 133 percent of the FPL. In relation to the federal Medicaid eligibility categories, this population actually spans two different technical groups:*
            - *"Poverty Level Pregnant Women," which covers women less than or equal to 133 percent of the 2010 FPL*
            - *"Qualified Pregnant Women," which covers women up to an income level that is roughly equivalent to 36 percent of the 2010 FPL*[116]
- Using the above example, a woman who would qualify under the standards for the Qualified Pregnant Women category (up to roughly 36 percent of the FPL) would also have an income that is less than that of the Poverty Level Pregnant Women category. Thus, categorizing the income limit for pregnant women as "less than or equal to 133 percent of FPL" captures the income limits for both categories.
- For more precise details about Medicaid eligibility, refer to the Wyoming Medicaid Online Eligibility Manual at http://ecom.health.wyo.gov.
- After summarizing the eligibility categories for Medicaid, we further organized similar categories into four major groups: Children, Pregnant Women, Family Care (adults) and Aged, Blind or Disabled. There are also four different categories of Other Groups. A comparison of these major groups shows that there are some notable differences in eligibility criteria, for example:
    - Individuals in the Children and Pregnant Women eligibility categories are not subject to resource limits, unlike the individuals who are eligible under the Aged, Blind or Disabled categories or selected Special Groups categories.
    - For those categories that are subject to resource limits based on the SSI standard, the amounts of such limits will vary depending on the eligibility category.
    - Individuals in most Medicaid eligibility groups receive full Medicaid benefits, except for individuals in the Medicare Savings Program, who receive assistance related to Medicare premium payments. Some individuals also receive further assistance with Medicare coinsurance and deductibles.

[116] Based on a comparison of the Family Care Income standard to the Federal Poverty Level guidelines.

APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Table 1: Summary of Wyoming Medicaid Eligibility Categories

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement[117]	Whose Income Counts	Income Level and Values for 2011[118]	Resource Limit for 2011
Children	Newborn	Full Medicaid coverage	Newborns up to age one with Medicaid eligible mothers	N/A; eligibility determined by mother's Medicaid eligibility		
	Child Zero Through Age Five		Under age six	Countable Family Income	Less than or equal to 133 percent of FPL 1 – $1,200 2 – $1,615 3 – $2,029 4 – $2,444	No resource limits
	Child Age Six Through Age 18		Under age 19		Less than or equal to 100 percent of FPL 1 – $903 2 – $1,214 3 – $1,526 4 – $1,838	
	Children in Foster Care		Up to age19; in DFS custody	Requirements vary by the type of foster care coverage or subsidized adoption		
	Aging-out Foster Care Program		Up to age 21			
	Subsidized Adoption		Under age 18; Under age 21 if child over 18 meets special needs			
Pregnant Women	Pregnant Women	Full Medicaid coverage	Pregnant	Countable Family Income	Less than or equal to 133 percent of FPL 1 – $1,200 2 – $1,615 3 – $2,029 4 – $2,444	No resource limits
	Presumptive Eligibility for Pregnant Women	Outpatient services, for a limited time				

[117] For more information about eligibility requirements, see the Eligibility section.
[118] Values listed by family size, for up to a family of four.

APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement[117]	Whose Income Counts	Income Level and Values for 2011[118]	Resource Limit for 2011
Family Care	Family Care	Full Medicaid coverage	Adult must have an eligible child, under age 19, living in the household	Countable Family Income	Less than or equal to the Family Care Income Standard 1 – $362 2 – $512 3 – $590 4 – $659	No resource limits
	Family Care 4 and 12 Month (Extended Medical)		Adult must have an eligible child, under age 19, living in the household Family unit must have received Family Care benefits for at least three of the previous six months		Exceeds the Family Care Income Standard due to increased income due to increased employment, increased salary, parent returning to work or child support.	
Aged, Blind, Disabled	Aged, Blind and Individuals in Institutions	Full Medicaid coverage	• Meets one or more requirements: ➢ Age 65 or older ➢ Blind by SSI standards ➢ Individual with disability by SSI standards • In institutional setting (i.e., nursing home, IMD, hospice care, inpatient hospital or ICF-MR)	Countable Personal Income	Less than or equal to 300 percent of the SSI payment standard for a single individual. Monthly SSI Payment Standard: $674 x 3 = $2,022	SSI Resource Limits: • Individual - $2,000 • Couple: when both are clients (initial certification only) - $2,000 Individually OR $3,000 Couple (whichever is most beneficial) • Community Spouse - $109,560
	Categories With Eligibility Determined by Social Security Administration (SSA)		N/A; eligibility determined by eligibility for SSI	Countable Personal Income and Spousal Income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard: Single – $674 Couple – $1,011	
	SSI Related Categories with Eligibility Determined by DFS	Full Medicaid coverage	• Must have lost SSI due to an increase or receipt of Social Security Benefits • Must disregard increase or SSA Benefit amount	Countable Personal Income	Countable income less than or equal to the Monthly SSI Payment Standard Single – $674 Couple – $1,011	SSI Resource Limits: • Individual - $2,000 • Couple - $3,000

APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement[117]	Whose Income Counts	Income Level and Values for 2011[118]	Resource Limit for 2011
Other Groups: Medicare Savings Program	Qualified Medicare Beneficiary	• Medicaid will pay Medicare Part A and B premiums • CMS assists with Medicare Part D premium payments • Receive medical deductible and coinsurance payment	Must be entitled to Part A and Part B of Medicare insurance	Countable Personal Income and Spousal Income	Less than or equal to 100 percent of FPL 1 – $903 2 – $1,214	Three times the SSI Resource Limits adjusted annually by the increase in the Consumer Price Index: • Individual - $6,680 • Couple - $10,020
	Specified Low-Income Medicare Beneficiary	Medicaid will pay Medicare Part B premium	Must be entitled to Part B of Medicare insurance		Less than or equal to 135 percent of FPL 1 – $1,218 2 – $1,639	
Other Groups: Specialty	Breast and Cervical Cancer Treatment Program	Full Medicaid coverage	• Between age 18 and 65 (if 65 or older must not be Medicare Part B eligible) • Meet the Preventative Health and Safety Division criteria • No insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B)	Countable Personal Income	Less than or equal to 250 percent FPL 1 – $2,256 2 – $3,035	No resource limits
	Wyoming Tuberculosis Program	Partial benefits related to tuberculosis Full Medicaid coverage	Provide verification of Tuberculosis	Countable Personal Income	Based on twice SSI Payment Standard, plus $65, plus $20 Monthly SSI Payment Standard: Single – $674 Couple – $1,011	SSI Resource Limits: • Individual - $2,000 • Couple: When both are clients (initial certification only) - $2,000 OR Individually $3,000 (whichever is most beneficial)
Other Groups: Medicaid Buy-in	Employed Individuals with Disabilities	Full Medicaid benefits after payment of premium (7.5 percent of gross monthly income)	• Age 16 through 64 • Disabled and employed	Countable Personal Income and Spousal Income	Unearned income less than or equal to 300 percent of the SSI standard for a single individual. Monthly SSI Payment Standard: $2,022	No resource limits

APPENDIX C: SUPPLEMENTARY TABLES AND CHARTS

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement[117]	Whose Income Counts	Income Level and Values for 2011[118]	Resource Limit for 2011
Other Groups: Non-citizens	Non-Citizens with Medical Emergencies	Benefits limited to services provided from the time treatment is given for a condition until that same condition is no longer considered an emergency	Illegal immigrants or qualified immigrants who do not meet citizenship criteria	Meets applicable eligibility requirements under an existing eligibility group		

Co-Payments

Table 1: Co-Payments

Type of Service	Co-Payment Amount	Exceptions
• Office Visits Procedure codes: 99201-99215 (The $2.00 co-payment only applies to these office visit codes when the place of service code is 11) • Home Visits Procedure codes: 99341-99350 • Eye Examinations Procedure codes: 92002, 92004, 92014 • Medical psychotherapy Procedure codes: 90804-90815 (The $2.00 co-payment only applies to these medical psychotherapy codes when the place of service code is 11) • Rural Health Clinic Encounters Procedure code: T1015 and Revenue code: 0521 • Federally Qualified Health Center Encounters Procedure code: T1015 and Revenue code: 0520	$2.00	Co-payment requirements do not apply to: • Recipients under age 21 • Nursing Facility Residents • Pregnant Women • Family Planning Services • Emergency Services • Hospice Services • Medicare Crossovers
Outpatient Hospital Visits (non-emergency) Revenue Codes: 450-459 and 510-519	$3.40	
Prescription Drugs	Generics (multisource medications) $1.00 All brand-name medications $3.00	Co-payment requirements do not apply to: • Recipients under age 21 • Nursing Facility Residents • Pregnant Women • Family Planning Services • Emergency Services • Hospice Services
Prescription Drug Assistance Program (PDAP) – State Funded	Generic Brand $10.00 Brand Name $25.00	

Birth Report

Table 1: Birth Report 1996 – 2010

Year	Number of Births in Wyoming	Number of Births Paid by Medicaid [119]	Percentage of Total Births Paid by Medicaid
1996	6,286	2,880	46%
1997	6,361	2,606	41%
1998	6,248	2,412	39%
1999	6,122	2,352	38%
2000	6,247	2,366	38%
2001	6,110	2,766	45%
2002	6,545	3,037	46%
2003	6,549	2,991	46%
2004	6,800	3,105	46%
2005	7,231	3,410	47%
2006[120]	7,640	3,452	45%
2007[121]	7,823	3,454	44%
2008	8,015	3,353	42%
2009	7,841	3,401	43%
2010	7,541	3,395	45%

[119] Medicaid statistics are based on paid claims for the 2010 calendar year.
[120] Data starting with 2006 is based on a calendar year. The data prior to 2006 was based on State fiscal year. The Provisional Statistics from Vital Records is always prepared by calendar year and the change was made to Medicaid data to reflect a calendar year so that it is the same time frame as Vital Records.
[121] Vital Records Office supplied the 2007 through 2010 provisional statistics.

APPENDIX D: GLOSSARY

Acquired Brain Injury (ABI) – Damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder.

Administrative Transportation – Transportation to and from medical appointments.

Ambulatory Surgical Center (ASC) – A location other than a hospital that performs outpatient surgery. At an ambulatory (in and out) surgery center, a patient might stay for only a few hours or for one night.

Ambulatory Payment Classifications (APC) – Medicare's prospective payment system for outpatient hospital services. All services paid are grouped into APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.

American Recovery and Reinvestment Act of 2009 (ARRA) – Legislation signed into law in February 2009 in response to the economic crisis. The Act specified funding for a wide range of federal programs, including certain benefits under Medicaid.

Average Manufacturer Price (AMP) – The average price paid to manufacturers by wholesalers for drugs distributed to a retail pharmacy.

Average Wholesale Price (AWP) – The published price for drug products charged by wholesalers to pharmacies.

Basic Life Support – Basic life support consists of essential non-invasive life-saving procedures including CPR, bleeding control, splinting broken bones, artificial ventilation, and basic airway management. This is usually provided by emergency medical service professionals.

Benefits Improvement and Protection Act of 2000 (BIPA) – Legislation signed into law in December 2000 that affects several aspects of Medicare and Medicaid.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs as well as research to support these programs.

Children's Health Insurance Program (CHIP) – A federal-state partnership program to provide free or low-cost health insurance for uninsured children under age 19. CHIP is intended for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. CHIP was formerly known as SCHIP, State Children's Health Insurance Program.

Cognos – The reporting tool used to extract claims data and Medicaid eligible and recipient information from Wyoming's Medicaid Management Information System (MMIS).

Commission on Accreditation of Rehabilitation Facilities (CARF) – An organization that accredits rehabilitation facilities.

Community Mental Health Center (CMHC) – A community-based healthcare facility that provides comprehensive mental health services to individuals residing or employed in the facility service area. These services are mostly ambulatory based.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy and speech pathology services.

Co-payment – A fixed amount of money paid by the Medicaid enrollee at the time of service.

Council on Accreditation (COA) – An organization that accredits healthcare organizations.

APPENDIX D: GLOSSARY

Crossover Claim – Services for Medicare and Medicaid dual eligible individuals where Medicare is the primary payer and Medicaid provides additional payments.

Deficit Reduction Act (DRA) – Legislation signed into law in February 2006 that affects several aspects of Medicare and Medicaid.

Department of Health and Human Services (HHS) – The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Diagnosis-Related Groups (DRG) – Medicare's prospective payment system (PPS) for inpatient hospital services reimburses a pre-determined rate for each Medicare admission based on each patients' clinical information.

Dispense as Written – Refers to the physician's instructions on a prescription to only dispense the brand name drug by writing "Brand Medically Necessary" on the prescription. A pharmacist may substitute a brand name drug with a generic drug when the physician has not written "Brand Medically Necessary" on the prescription.

Disproportionate Share Hospitals (DSH) – Hospitals that serve high volumes of low-income patients receive a payment adjustment under Medicare's prospective payment system or under Medicaid.

Drug Rebate Program – Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate program requiring brand and generic pharmaceutical manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive federal funding for outpatient drugs dispensed to Medicaid patients.

Drug Utilization Review (DUR) – A review utilization of outpatient prescription drugs to determine if recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – Medical equipment and other supplies that are intended to reduce a patient's physical disability and restore the patient to his or her functional level.

Dual Eligible – A low-income individual who qualifies for both Medicaid and Medicare.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – The comprehensive and preventive child health component of Medicaid for individuals under the age of 21. Medicaid's EPSDT services are operated under the Health Check program. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

Eligibility – Refers to the process whereby an individual is determined to be eligible for healthcare coverage through the Medicaid program. The State determines eligibility.

Eligible Individual – For purposes of this Report, an individual enrolled in Medicaid who is eligible to receive services during the SFY.

End-Stage Renal Disease (ESRD) – The complete, or almost complete, failure of the kidneys to function. The only treatments for ESRD are dialysis or kidney transplantation.

Estimated Acquisition Cost (EAC) – The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug.

APPENDIX D: GLOSSARY

Expenditure – The issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred.

Explanation of Benefits (EOB) – An itemized statement of services provided by a third-party payer.

Federal Fiscal Year (FFY) – The 12 month accounting period, for which the federal government plans its budget, usually running from October 1 through September 30. The SFY is named for the end date of the year, e.g. FFY 2009 ends on September 30 2009.

Federal Medical Assistance Percentage (FMAP) – The portion of the Medicaid program, which is paid by the Federal government.

Federal Poverty Level (FPL) – The amount of income determined by the federal Department of Health and Human Services to provide a minimum for living necessities.

Federally Qualified Health Center (FQHC) – A health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement and provide direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives.

Fee Schedule – A complete listing of fees used by health plans to pay doctors or other providers.

Federal Upper Limit (FUL) – The maximum price pharmacies receive as reimbursement for providing multiple-source generic prescription drugs to Medicaid recipients. The FUL is established by CMS in order to achieve savings by taking advantage of current market pricing. Not all drugs have FULs and states may establish reimbursement limits for non-FUL drugs using other pricing methodologies.

Healthcare Common Procedure Coding System (HCPCS) – A medical code set that identifies healthcare procedures, equipment and supplies for claim submission purposes.

Home and Community-Based Services (HCBS) – Care provided in the home and community to individuals eligible for Medicaid. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled and certain other disabled adults.

HCBS Waiver for Adults with Developmental Disabilities – A home and community-based services waiver developed for adults with developmental disabilities to assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

HCBS Waiver for Adults with Acquired Brain Injury – A home and community-based services waiver developed for adults from ages 21 to 65 with acquired brain injuries to assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

HCBS Waiver for Assisted Living Facilities – A home and community-based services waiver that provides assisted living facility services for recipients 19 years of age and older who require services equivalent to a nursing home facility level of care.

HCBS Waiver for Children with Developmental Disabilities – A home and community-based services waiver developed for children from birth up to age 21 with developmental disabilities to assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

HCBS Waiver for Children's Mental Health – A home and community-based services waiver that provides treatment for youth with serious emotional disturbances that allows them to stay in their communities.

HCBS Waiver for Long Term Care – A home and community-based services waiver that provides in-home services for recipients 19 year of age and older who require services equivalent to a nursing home facility level of care.

APPENDIX D: GLOSSARY

Health Professionals Shortage Area (HPSA) – The Health Resources and Services Administration Shortage Designation Branch indicates whether a geographic area, population group or facility designated has a shortage of primary medical care, dental or mental health providers.

Home Health – For the purposes of this Report, defines a category of services that are limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers), medical supplies and other services.

Hospice – For the purposes of this Report, defines a category of services that are for people who are terminally ill. This care includes physical care and counseling.

Inpatient – For the purposes of this Report, defines a category of services that are provided to a patient admitted for overnight stay in a hospital or health service facility receiving diagnostic treatment.

Intermediate Care Facility for the Mentally Retarded (ICF-MR) – A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care available in a hospital or skilled nursing facility.

Individualized Budget Amount (IBA) – In the developmental disability and acquired brain injury waiver programs, the amount of funding allocated to each consumer based on individual characteristics and his or her service utilization.

Interpreter Services – Services that provide interpretation for individuals with limited English proficiency or who are hearing impaired.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – An organization that accredits healthcare organizations.

Level of Care (LOC) – Medicaid's prospective payment system for inpatient hospital services. Medicaid pays an amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedures and revenue codes that hospitals report on the inpatient claim.

Limited English Proficiency (LEP) – The inability to speak, read, write or understand the English language at a level that permits an individual to interact effectively with healthcare providers.

Lock-in – Medicaid may restrict or "lock-in" recipients to a certain provider if the recipient's utilization of services is documented as being excessive. This program is intended to prevent Medicaid recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

Median – The median, or 50^{th} percentile, is the middle value of a set of numbers. The median divides the set of numbers into two equal parts.

Medicaid – A joint federal-state program, authorized by Title XIX of the Social Security Act, that provides medical benefits for certain low-income persons in need of health and medical care.

Medicaid Eligibility – Criteria that establish an individual's ability to enroll in Medicaid and receive Medicaid services. The federal government establishes minimum eligibility criteria that all states must follow, but every state has some flexibility to determine other, optional populations to cover within federal guidelines.

Medicaid Management Information System (MMIS) – A CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.

Medicaid Savings Program – Medicaid programs that help pay some or all Medicare premiums and deductibles.

APPENDIX D: GLOSSARY

Medicaid State Plan – The document that defines how each state will operate its Medicaid program. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

Medicaid Waiver – States have the option of applying for certain waivers to operate their Medicaid programs outside of typical State Plan restrictions.

Medicare – A federal program, authorized by Title XVIII of the Social Security Act, that provides medical benefits for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD).

Medicare Economic Index (MEI) – An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule. Medicaid uses the index as an update factor for FQHC and RHC reimbursement rates.

Outpatient – For the purposes of this Report, defines a category of services that are medical or surgical in nature and do not include an overnight hospital stay. These services are often provided within one day (24 hours) at a hospital outpatient department or community mental health center.

Participating Provider – A participating provider is defined as all hospitals within Wyoming that are providers, and all out-of- state hospitals that were paid $250,000 or more by Medicaid during the period from July 1, 1994, through December 31, 1996. Participating providers also include all rehabilitation facilities and psychiatric hospitals that received Medicaid funds during the period from July 1, 1994, through December 31, 1996.

Percentile – A value on a scale that indicates the percent of a distribution that is equal to it or below it. For example, a score at the 50th percentile is equal to or higher than 50 percent of the scores. The 50th percentile is also called the median value.

Pharmacy Benefit Manager (PBM) – Third party administrator of prescription drug programs.

Pharmacy & Therapeutics (P&T) Committee – A committee comprised of six physicians, five pharmacists, and one allied health professional who meet four times a year to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to the Medicaid Pharmacy Program.

Preferred Drug List (PDL) – A list of clinically sound and cost effective prescription drugs covered by Medicaid that do not require prior authorization.

Pregnant by Choice Waiver – An Medicaid program that provides family planning services and birth control options through a Section 1115 Medicaid waiver to women who have received Medicaid benefits through the Pregnant Women program and who would otherwise lose eligibility 60 days after giving birth.

Prior Authorization (PA) – The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a pharmacy benefit management (PBM) plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing. Also known as a medical-necessity review.

Psychiatric Residential Treatment Facility (PRTF) – A facility that provides services to individuals who require extended care beyond acute psychiatric stabilization or extended psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter-term care.

Qualified Rate Adjustment (QRA) – Medicaid's annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA

APPENDIX D: GLOSSARY

Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. QRA payments are only available to in-state hospitals for inpatient and outpatient services.

Recipient – For purposes of this Report, an individual enrolled in Medicaid who also receives services during the SFY.

Resource Based Relative Value Scale (RBRVS) – Established as part of the Omnibus Reconciliation Act of 1989, Medicare payment rules for physician services were altered by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a dollar conversion factor.

Rural Health Clinic (RHC) – An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

Section 1115 Waiver – A Medicaid pilot or demonstration project authorized by Section 1115 of the Social Security Act.

Social Security Act – The legislation, signed in 1965 that authorized Medicare, under Title XVIII, and Medicaid, under Title XIX.

State Fiscal Year (SFY) – The 12 month accounting period for which the state plans its budget, usually running from July 1 through June 30. The SFY is named for the end date of the year, e.g. SFY 2009 ends on June 30 2009.

State Maximum Allowable Cost (SMAC) – The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic drug products established by the Medicaid Pharmacy Program. The Medicaid Pharmacy Program may include more drugs than are covered under the FUL program as well as set reimbursement rates that are lower than FUL rates.

Supplemental Security Income (SSI) – The Social Security Administration (SSA) pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits.

Third Party Liability (TPL) – The legal obligation of third parties, e.g., private health insurance, Medicare, to pay all or part of the expenditures for medical assistance furnished under a State plan.

Usual and Customary Charge – The fee that is most consistently charged by a healthcare provider for a particular procedure. The actual price that pharmacies charge cash-paying customers for prescription drugs.

APPENDIX E: ACRONYMS

Acronym	Term
ARRA	American Recovery and Reinvestment Act of 2009
ABD	Aged, Blind or Disabled
ABI	Acquired Brain Injury
ALF	Assisted Living Facility
AMP	Average Manufacture's Price
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center
AWP	Average Wholesale Price
BIPA	SCHIP Benefits Improvement and Protection Act of 2000
CARF	Commission on Accreditation of Rehabilitation Facilities
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
DD	Developmental Disabilities
DFS	Department of Family Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotic and Supply
DRA	Deficit Reduction Act
DRG	Diagnosis-Related Groups
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESRD	End State Renal Disease
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HPSA	Health Professionals Shortage Area

APPENDIX E: ACRONYMS

Acronym	Term
IBA	Individualized Budget Amount
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
I/OCE	Integrate Outpatient Code Editor
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	Limited English Proficiency
LOC	Level of Care
HCBS/LTC	Long-Term Care Home and Community-Based Services
MEI	Medicare Economic Index
MFCU	Medicaid Fraud Control Unit
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MMIS	Medicaid Management Information System
OHCF	Office of Healthcare Financing under the Wyoming Department of Health
OPPS	Outpatient Prospective Payment System
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
PAB	Psychiatrist Advisory Board
PBM	Pharmacy Benefit Manager
PDL	Preferred Drug List
POS	Prosthetic, Orthotic and Supply
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility
QMB	Qualified Medicare Beneficiaries
QMS	Quality Management Strategy
QRA	Qualified Rate Adjustment Payments
RBRVS	Resource Based Relative Value Scale
RHC	Rural Health Clinic
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiaries
SMAC	State Maximum Allowable Cost
SSDC	Sovereign States Drug Consortium
SSI	Supplemental Security Income
TB	Tuberculosis
TPL	Third Party Liability